STATE OF ILLINOIS)
) SS.
COUNTY OF)
ROCK ISLAND

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Fidelia Favela,

Petitioner,

vs. NO: 11 WC 05517

Great Dane Trailers,

Respondent.

15IWCC0604

DECISION AND OPINION ON REVIEW

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

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

- Petitioner is a 49 year old employee of Respondent, who on the date of accident sustained an injury then involving her left hand. On the date of accident, December 6, 2010, Petitioner testified her left hand was caught in a riveting machine that resulted in the injuries to her left hand. Petitioner testified that after the accident she was taken immediately to the hospital and she then came under the care of Dr. James Williams who had performed surgery on her left hand and kept Petitioner off of work for a period of time. Petitioner completed her treatment with Dr. Williams and underwent physical therapy to her left hand post-surgery. Petitioner testified that Dr. Williams eventually allowed her to return to work after she had a functional capacity evaluation (FCE) where they tested her left hand. Dr. Williams released Petitioner with permanent restrictions.

Petitioner testified that prior to December 6, 2010 she had no problems with her left hand, left thumb, left index finger, or left middle finger. Petitioner testified that when she returned to work at Respondent she was not doing the same job she did before the accident; Petitioner stated she now does cleaning. Petitioner did not do cleaning before the accident.

- Petitioner testified that as to her left hand and left fingers, she has lost strength and she has great difficulty grasping/grabbing things and now must almost exclusively have to use her right hand to do her work. Petitioner testified that she had pain in her left hand and fingers; during the cold she had a lot of pain in her finger and she cannot press down with her left hand. Petitioner testified she generally feels pain throughout the area. Petitioner testified that she feels pain on the sides of her left thumb and any time she strikes it it hurts her a lot. As to her left index finger, Petitioner testified she feels pain at the very tip when it gets very cold and something strikes it. Petitioner also stated that she feels pain along the side of the finger and that some pain also radiates and extends all the way up her arm, but typically she does not feel anything at the tip of her finger. As to her left middle finger, Petitioner testified that the bone just underneath protrudes under the surface and she cannot apply pressure or use downward or grasping pressure with it. Petitioner testified that when it is cold it just hurts on its own and she generally lacks the ability to apply any strength with that finger. Petitioner has no pain to the palm of her hand or the upper part of her hand, but when it gets cold the pain begins to radiate all the way up her arm and when cold she can only use her left little and ring fingers. Petitioner testified that sometimes she can close her left hand all of the way, but when she closes it she feels a lot of cramping. Petitioner indicated that it has gotten worse and she just feels the cramping sensation and then she cannot close it all the way. Petitioner testified that if she tries to pick up something at work, like a bucket, her strength to carry things is just not the same. Petitioner had no future medical appointments scheduled.

- Per the record, the Arbitrator examined Petitioner's left hand/fingers and he noted she was clearly missing her left thumb up to her knuckle. The Arbitrator noted the index finger was missing maybe from the first knuckle, just behind the knuckle it was a bit disfigured/pointy. The Arbitrator noted the middle finger appeared to be just missing the tip. He noted when Petitioner opened or closed her left hand she did so slowly and did not appear to be able to completely close it.

The Commission finds that Petitioner testified of the accident and treatment and ongoing problems. The medical records support and are consistent throughout. Petitioner's testimony is unrebutted. The evidence and unrebutted testimony in this record finds Petitioner met the burden of proving an ongoing causal relationship between her left thumb, left index finger, left middle finger, as well as to her left hand in general. The Commission finds the decision of the Arbitrator as not contrary to the weight of the evidence, and, herein, affirms and adopts the Arbitrator's finding as to causal connection.

The Commission finds that the Arbitrator used the minimum 'PTD and death rate' for the date of

accident regarding the thumb amputation. The thumb should be at the minimum PPD rate of $462.54 for amputation (Minimum for amputations should be at half of State AWW; per §8(b) 4.1; the State AWW for date of accident was $925.08 so 50% of that equals $462.54) The Commission finds the decision of the Arbitrator as contrary to the weight of the evidence (erroneous rate for the amputation) and, herein, modifies regarding amputation PPD rate regarding the thumb to **$462.54** (min per §8(b) 4.1) and otherwise affirms and adopts the Arbitrator's finding as to the remaining permanent partial disability benefit rate.

The Commission notes that the December 6, 2010, operative report, noted a diagnosis of a crush injury to the left hand. The operative report also noted left middle finger irrigation, debridement and wound closure; left thumb shortening amputation and wound closure just distal to IP joint of left thumb; index finger on left hand shortened and wound closure at distal IP joint. Dr. Williams December 27, 2010 progress note indicated the injury and further noted that Petitioner lost the distal 2/3 of distal phalanx of IP joint of her left thumb; lost at DIP joint of her left index and only a significant laceration at the left middle. Petitioner noted her ongoing problems not only with her thumb, index, and middle fingers but also weakness of her hand generally and the pain going from her fingers/thumb up her arm at times as well as numbness and problems closing her fist fully (as noted by the Arbitrator); Petitioner's complaints were supported with the evidenced medical records.

The Commission finds the evidence indicates a 100% amputation of the left thumb (76 weeks), but the award should have been at the minimum rate for statutory amputation at $462.54 as noted above (total PPD for 100% amputation of Petitioner's thumb, $35,153.04). Respondent paid $30,565.57 in PPD (per stipulation sheet) towards the thumb amputation. The 50% loss of use of the left index finger is affirmed; 21.5 weeks at $300.64 per week, totaling $6,463.65. The 15% loss of use of the middle finger is affirmed; 5.7 weeks at $300.64 per week, totaling $1,713.65 for a fracture of the distal phalanx; appropriate given the lesser complaints. Those awards of PPD would be consistent with Commission awards of a similar nature and result. The Commission finds, however that, as to the 15% loss of use of her hand, that portion of the PPD award is insufficient given Petitioner's significant left hand (albeit non-dominant) problems. Petitioner's left hand is weaker and she has pain using her hand that does radiate up in the cold and with using pressure with her injured left fingers/hand. As Petitioner is a line worker who uses her hands and has permanent left hand restrictions of very limited use, the award for Petitioner's left hand is considered low compared with prior Commission decisions of similar nature, and therefore, herein, the Commission modifies to find a 25% loss of use of Petitioner's left hand (51.25 weeks at $300.64 per week, totaling $15,708.44), over and above the losses of the fingers. The higher award regarding the hand is supported in the evidence and testimony, and more consistent with prior Commission decisions of similar nature and outcome. The Commission finds the decision of the Arbitrator as not totally contrary to the weight of the evidence, and herein, modifies as to the benefit rate for the thumb amputation to $462.64, and modifies the loss of use of hand award to 25% (51.25 weeks), and otherwise affirms and adopts the Arbitrator's finding as to nature and extent of the Permanent partial disability and benefit rate as to the remaining PPD award as indicated above.

15IWCC0604

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $462.54 per week for a period of 76 weeks, as provided in §8(e)(1) & §8(b) 4.1 of the Act, for the reason that the injuries sustained caused the 100% loss of use of Petitioner's left thumb (amputation); $300.64 per week for a period of 21.5 weeks, as provided in §8(e)(2) of the Act, for the reason that the injuries sustained caused the 50% loss of use of Petitioner's left index finger; $300.64 per week for a period of 5.7 weeks, as provided in §8(e)(3) of the Act, for the reason that the injuries sustained caused the 15% loss of use of Petitioner's left middle finger; and $300.64 per week for a period of 51.25 weeks, as provided in §8(e)(9) of the Act, for the reason that the injuries sustained caused the 25% loss of use of Petitioner's left hand.

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 $28,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 3 - 2015
o-5/28/15
DLG/jsf

David L. Gore

Stephen Mathis

Mario Basurto

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

FAVELLA, FIEDLIA
Employee/Petitioner

Case# **11WC005517**

GREAT DANE TRAILERS
Employer/Respondent

15IWCC0604

On 8/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0252 HARVEY & STUCKEL
DAVID STUCKEL
101 S W ADAMS ST SUITE 600
PEORIA, IL 61602

1872 SPIEGEL & CAHILL PC
PATRICK J JESSE
15 SPINNINGWHEEL RD SUITE 107
HINSDALE, IL 60521

15IWCC0604

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Fidelia Favella
Employee/Petitioner

v.

Great Dane Trailers
Employer/Respondent

Case # **11** WC **5517**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Rock Island**, on **June 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 6, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**26,055.64**; the average weekly wage was $**501.07**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

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

Respondent is entitled to a credit of $**30,565.57** for Permanent Partial Disability benefits previously paid to the Petitioner.

ORDER

Respondent shall pay Petitioner permanent partial disability benefits of $**466.13**/week for **76** weeks, because the injuries sustained caused the **100%** loss of the **left thumb**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**300.64**/week for **57.95** weeks, because the injuries sustained caused the **50%** loss of the **left index finger**, the **15%** loss of the **left middle finger**, and the **15%** loss of the **left hand**, as provided in Section 8(e) of the Act.

Respondent is entitled to a credit of $**30,565.57** for Permanent Partial Disability benefits previously paid to the Petitioner.

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

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

Arbitrator Anthony C. Erbacci

July 31, 2014
Date

AUG - 4 2014

15IWCC0604

FACTS:

On December 6, 2010, the Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent when her left hand got caught in a riveting machine. Immediately following her injury, the Petitioner was transported to the emergency room at Kewanee Hospital where it was noted that the Petitioner had sustained a crush injury to her left thumb, index finger and middle finger. The Petitioner underwent x-rays which were reported to demonstrate comminuted fractures of the thumb, index and long finger. After emergency care was rendered, the Petitioner was discharged on the same date and referred to a hand specialist for further evaluation.

The Petitioner then came under the care of Dr. James Williams at OSF St. Francis Medical Center. On December 6, 2010 Dr. Williams performed a left middle finger irrigation, debridement and wound closure, a left thumb shortening amputation and wound closure just distal to the interphalangeal joint of the left thumb, and a left index finger shortening and wound closure at the distal interphalangeal joint. Dr. Williams prescribed post-operative therapy and he kept the Petitioner off work for the next two weeks.

The Petitioner followed up with Dr. Williams on December 27, 2010 and he released her to return to work light duty with no use of the left hand. The Petitioner continued to participate in therapy and to follow up with Dr. Williams. On February 3, 2011 it was noted that the Petitioner was working 4 hours a day with no use of the left hand and that she was able to do that without difficulty.

On March 3, 2011, the Petitioner was released to return to work with light duty restrictions, a two pound weight limit on the left hand, and instructions to transition to 8 hour shifts, 3 days a week with no impact or vibratory tools. On March 31, 2011, Dr. Williams indicated that the Petitioner had done well and was able to make a full fist with the middle finger and was able to move her fingers down to the distal palmar crease with good motion at the PIP and DIP joints. Dr. Williams did note stiffness in the Petitioner's index finger and he recommended a functional capacity evaluation along with weaning the Petitioner off Lyrica.

The petitioner underwent a functional capacity evaluation on April 12, 2011 and it was noted to demonstrate that the Petitioner was able to perform within the sedentary physical demand level. It was noted that her effort was consistent during the examination approximately 75% of the time and that there were some mild self-limiting behaviors. The Petitioner was recommended to undergo a course of work conditioning which she began in May of 2011.

The Petitioner was last seen by Dr. Williams on June 27, 2011. Dr. Williams noted that the Petitioner had done well, and he placed her at maximum medical improvement and returned her to work with permanent restrictions of 25 pounds of lifting on the left arm, 50 pounds with both arms and no vibratory tools. Dr. Williams released the Petitioner from his care on that date.

The Petitioner testified that she has not sought care for her left thumb, index or middle fingers since the date of discharge. She testified that she did not return to her same job and now primarily does cleaning. The Petitioner testified that she currently notices a loss of strength in her left hand along with difficulty gripping. She testified that she almost exclusively uses her right, dominant, hand. With respect to her thumb, she testified that she will experience pain if she presses down or if the thumb is struck. She indicated that pain will occur in her index finger when it becomes very cold. She indicated that she "cannot apply pressure" with her left middle finger. The Petitioner testified that she occasionally experiences pain in her left hand that shoots up through her arm when it is cold. The Petitioner testified that she only takes Ibuprofen for pain and sometimes uses topical cream.

The Arbitrator notes that, at hearing, the Petitioner attempted to close her left hand into a fist and indicated that she could not do so. The Arbitrator was able to personally observe the Petitioner's left index finger, thumb and middle finger. The Arbitrator notes that the Petitioner was missing the tip of the thumb up to the knuckle and missing the tip of her index finger.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent when her left hand got caught in a riveting machine on December 6, 2010. The Petitioner was taken to the emergency room directly from the scene of the accident immediately after it occurred, and x-rays demonstrated comminuted fractures of the thumb, index finger, and long finger. Thereafter, the Petitioner underwent a continuous course of medical care and treatment through June 27, 2011 when she was released from care with permanent restrictions. The Petitioner testified that she continues to experience pain and a loss of grip strength in her left hand, and she testified that she has not experienced any other prior or subsequent injuries to her left hand.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's current condition of ill-being is causally related to the work injury of December 6, 2010.

In Support of the Arbitrator's Decision relating to (L.), What is the nature and extent of the injury, the Arbitrator finds and concludes as follows:

The Petitioner sustained a crush injury to her left hand when it was caught in a machine. The Petitioner was diagnosed with comminuted fractures of the left thumb, index and long fingers with soft tissue swelling and disruption. The Petitioner then underwent

surgery consisting of a left middle finger irrigation, debridement and wound closure, a left thumb shortening amputation and wound closure just distal to the interphalangeal joint of the left thumb, and a left index finger shortening and wound closure at the distal interphalangeal joint. The Petitioner participated in a course of post-operative physical therapy and eventually completed a functional capacity evaluation. She was ultimately placed on permanent restrictions, with a 25 pound weight limit on her left arm and 50 pounds using both arms together, and no use of any power tools.

The Petitioner has returned to work for the Respondent in a different position doing cleaning work. The Petitioner testified that since returning to work she has been limited to a cleaning job and has never returned to her pre-injury work. The Petitioner testified that she continues to experience pain in her hand and forearm, hyper-sensitivity in her left thumb, index and middle fingers and lack of grip strength. The Arbitrator observed the Petitioner attempt to make a fist with her left hand and noted that she could not close her hand. She also has an enlarged tip of the middle finger and the distal phalanx is misaligned. The Petitioner testified that cold weather aggravates her hand pain and the she basically does not use her left hand to perform work activities and depends almost solely on her right hand.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing including the medical records, the Petitioner's testimony and the observations of the Arbitrator, the Arbitrator finds that the Petitioner has sustained a loss of 100% of her thumb, 50% of her index finger, and 15% of her middle finger. In addition, the Arbitrator finds that the Petitioner's injuries have also resulted in limitations on her ability to use her left hand as reflected by the permanent restrictions imposed by Dr. Williams. Thus, the Arbitrator finds that the Petitioner has also sustained a 15% loss of use of the left hand.

The minimum Permanent Partial Disability rate for the amputation of a member on the date of the Petitioner's injury is $466.13 per week. Thus, the 100% amputation of the Petitioner's thumb is compensable at the rate of $466.13 per week. The less than 100% loss to the Petitioner's index finger, as well as the partial loss of use of her middle finger and the partial loss of use of her left hand, is compensable at the rate of $300.64 per week. The parties stipulated that Respondent has paid the sum of $30,565.57 toward permanent disability and is entitled to credit in that amount.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Christine Padgett,
Petitioner,

vs. NO: 97 WC 64118

Taco Bell,
Respondent,

15IWCC0605

DECISION AND OPINION ON REVIEW

Petition for Review under §8(a) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of prospective medical treatment and being advised of the facts and law, finds the following:

The Respondent will provide Petitioner with an intra-thecal narcotic pain pump as prescribed by Dr. Roland and endorsed by Dr. Ghanayem.

The Petitioner testified to her leg giving way 3 or 4 times since her original hearing. The last time her leg gave way was in March of 2013. (Transcript Pgs. 17-19) Dr. Roland has given her three or four epidurals since 2013. (Transcript Pgs. 9-10) She also had a spinal cord stimulator that shifted when she fell in 2013. As a result, she wound up in the Riverside Emergency room with an infection. (Transcript Pgs. 11-12)

She further testified that because of her pain medications, her stomach pain has increased and she cannot eat unless she has muscle relaxers. Even with the muscle relaxers, it is difficult for her to eat. (Transcript Pgs. 9-10)

Dr. Roland, the Petitioner's treating doctor, prepared a letter of necessity regarding a pain pump. This pump, according to the doctor, would replace the oral medication with fewer side effects and will control the pain in her lower back. According to the doctor, he sent a request to the insurance company for an implantation of an intra-thecal narcotic pain pump, which was denied. (Petitioner Exhibit 1)

Dr. Ghanayem, who was also the original Respondent's doctor, found that Dr. Roland's

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recommendations of a pain pump was "sound and are indeed related to her back injury and residuals from that." (Petitioner Exhibit 2)

Dr. Noren prepared a medical report on behalf of the Respondent in which he opined that the intra-thecal therapy was not indicated. (Respondent Exhibit 2) At the Arbitration hearing, Arbitrator Falcioni found Dr. Noren's opinions to be not credible. We see nothing in the record that would change our minds regarding Arbitrator's opinion of Noren's credibility.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent authorize the treatment and use of the intra-thecal pain pump as prescribed by Dr. Roland.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 4 - 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 6/9/15
049

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANINA LISKOWIAK, widow of
ZBIGNIEW LISKOWIAK, Deceased,

Petitioner,

15IWCC0607

vs.

NO: 11 WC 003046

PRESTIGE DECORATING,

Respondent.

ORDER ON REMAND

This matter is again before the Commission pursuant to the September 17, 2014, Opinion and Order of Judge Carl Anthony Walker of the Circuit Court of Chicago. Said Opinion and Order requests of the Commission to explain its March 26, 2013, Order, an order in which $33,934.26 was awarded as attorney's fees. Given the limited scope of the Opinion and Order and noting the accurate recitation of the factual and procedural histories in this matter, the Commission declines to repeat said histories in this Order on Remand. The Commission, instead, limits its Order on Remand to explain its rationale with respect to the awarded attorney's fees.

Petitioner Janina Liskowiak ("Liskowiak") entered into an Attorney Representation Agreement with Bellas & Wachowski ("Wachowski") on January 12, 2011, with Peter C. Wachowski signing on behalf of Wachowski, to prosecute her claim against Respondent Prestige Decorating ("Respondent") with respect to the injuries her late husband, Zbigniew Liskowiak, sustained on November 11, 2010. The terms of compensation are codified in the Act and were reproduced in the controlling Attorney Representation Agreement as noted below:

15IWCC0607

In return for representation before the Commission, the client agrees to pay the attorney a sum of money equal to:

A. 1. 50% of any amount received in excess of the written offer, if any, or 20% (not to exceed 20%) of the total amount received for compensation for permanent disability caused by the accident, whichever is less; provided, however, if the compensation received for permanent disability does not exceed the written offer, the attorney shall receive no fee for permanent disability; or

2. $100.00 (not to exceed $100) if the respondent does not dispute its liability, the proper amount is paid timely, the client does not receive more than that specified by law, and the accident resulted in any of the following: death of the employee; amputation of one or more fingers, toes, or body parts; removal of a testicle; enucleation or 100% loss of vision in an eye; fracture of one or more vertebra, spinous or transverse process, or facial bones; fracture of a skull; removal of a kidney, spleen, or lung; and

B. 20% (not to exceed 20%) of any compensation for temporary total disability that the employer refused to pain in a timely manner or in the proper amount; and

C. 20% (not to exceed 20%) of all disputed medical bills; and

D. In addition to the above, all costs and expenses of advocating the above claim.

No settlement shall be made without the consent to the client. There will be no charge unless recovery is made.

If the client terminates this agreement before recovery, the client will pay the attorney for a reasonable fee, as determined by the Illinois Workers' Compensation Commission, from the subsequent recovery (not to exceed the amounts listed in A-C above) plus any unpaid expenses related to advocating the claim up to the date the agreement ended.

Both Liskowiak and Wachowski cite paragraph A as containing the controlling language in this matter, with Liskowiak relying on paragraph A2 and Wachowski relying on paragraph A1. The Commission finds it is not a matter of finding one paragraph more applicable than another. Rather, the Commission finds paragraph A1 to be applicable and paragraph A2 to not be applicable.

Paragraph A2 stipulates that an attorney's compensation is to be capped at $100.00 in situations in which the respondent does not dispute its liability and the accident resulted in the death of an employee. It is noted in paragraph A2 the word "and" is used as a conjunction, indicating there has to be both no dispute as to liability and the death of an employee for the compensation limit as set forth in paragraph A2 to become operative. It is further noted that a

15IWCC0607

dispute of liability is not limited to a defined issue. Accordingly, the Commission finds a respondent contesting any issue is sufficient to make paragraph A2 inoperative. In the present matter, it is noted in both the Request for Hearing as well as the Arbitration Decision filed with the Commission on September 24, 2012, that liability for unpaid medical bills was an issue Respondent contested, with the Arbitration Decision stating, "The respondent disputed and contested liability, and did not pay any benefits until August 2012." The Commission, therefore, finds paragraph A2 to be inoperative due to Respondent disputing liability.

Respondent disputed liability and, as a result, paragraph A1 came into effect. There is no evidence of or claim made that a written settlement offer was tendered by Respondent to Liskowiak. Thus, the Commission does not entertain the provision within paragraph A1 in which that scenario is discussed. The absence of a written offer leaves only the provision contained within paragraph A1 of "20% of the total amount received for compensation for permanent disability caused by the accident . . ." as the only means to determine a proper amount of compensation. The Commission, however, notes claims involving death cases, the compensation is not the stipulated 20% of the total amount received for compensation. Section 16a of the Act sets forth, "in death cases . . . the amount of an attorney's fees shall not exceed 20% of the sum which is due under this Act for 364 weeks of permanent total disability based upon the employee's average gross weekly wage prior to the date of the accident . . . unless further fees shall be allowed to the attorney upon a hearing by the Commission fixing fees." 820 ILCS 305/16a (2013).

Applying the formula as set forth under Section 16a, the Commission finds the proper compensation to Wachowski to be $33,934.26. The decedent's gross average weekly wage, as stipulated, was $520.00. The compensation rate, per Section 8(f), would leave a compensation amount below the statutory minimum compensation rate for accidents involving deaths occurring in 2010. The statutory minimum compensation rate for such accidents is $466.13 per week. As the Act limits attorney compensation in death cases to 20% of the sum which is due under this Act for 364 weeks, $466.13 is multiplied by the statutorily-prescribed 364 weeks and results in a sum $169,671.32. Twenty percent of that amount is $33,934.26.

Per the record, liability was an issue resolved only by the September 24, 2012, Arbitration Decision. Contained within said decision was an award with respect to the contested issue. The Commission, accordingly, finds Wachowski successfully represented Liskowski's interests and merits the compensation as permitted under the Act, as defined in the executed January 12, 2011, Attorney Representation Agreement and as awarded by the Arbitration Decision.

IT IS HERE BY ORDERED BY THE COMMISSION that Liskowiak pay to Wachowski the attorney's fees as awarded in the September 24, 2012, Arbitration Decision;

15IWCC0607

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to reissue the check originally issued on August 7, 2012, in the amount of $49,951.70 to allow for disbursement to Wachowski;

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to pay to Wachowski twenty percent (20%) of all payments previously made to Liskowiak; and

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to pay all future attorney's fees related to this matter directly to Wachowski.

DATED: AUG 5 - 2015
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☒ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES PARRA,

Petitioner,

15IWCC0606

vs.

NO: 12 WC 43353

ADMIRAL HEATING & VENTILATING,

Respondent.

DECISION AND OPINION ON REMAND

This matter come before the Illinois Workers' Compensation Commission on remand from the Circuit Court of Cook County in case number 14 L 50467. On June 12, 2013 Arbitrator Williams issued 19(b) Decisions in 12 WC 43353 and in 13 WC 00609. In 12 WC 43353, the Arbitrator found Petitioner failed to prove he sustained accidental injuries, to his right elbow and low back, arising out of and in the course of his employment with Respondent on November 14, 2012, and that Petitioner failed to provide timely notice of his claim of injury. In 13 WC 00609, the Arbitrator found Petitioner failed to prove he sustained accidental injuries, to his right elbow and low back, arising out of and in the course of his employment with Respondent on August 17, 20011, and that Petitioner failed to provide timely notice of his claim of injury.

On Remand Order:

> "The Illinois Workers' Compensation Commission's Decision and Opinion on Review of Case No. 14 IWCC 0362 is substantively and procedurally deficient in a number of areas – including an articulation for the bases [sic] for its Decision and the reasonableness of its Decision."

On June 21, 2013, Petitioner timely filed a Petition for Review in 12 WC 43353 and 13 WC 00609, raising issues of accident, notice, causal connection, medical expenses, temporary total disability, prospective medical care, and penalties and fees.

On February 11, 2014 oral arguments were heard in the matter, with both parties represented by counsel. On May 16, 2014, the Commission, after considering the issues of accident, notice, causal connection, medical expenses, temporary total disability benefits, prospective medical care, and penalties and fees, and being advised of the facts and law, reversed the Decision of the Arbitrator with regard to Petitioner's right elbow injuries sustained on November 14, 2012, in 12 WC 43353, but affirmed the Arbitrator's finding in 13 WC 609 that Petitioner failed to prove accidental injuries arising out of and in the course of employment and causal connection with regard to Petitioner's alleged right elbow and low back injuries on August 17, 2011. The Commission further remanded 12 WC 43353 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).

Pursuant to Judge Robert Lopez Cepero's November 14, 2014 Remand Order, the Commission herein provides further articulation for the basis for its Decision.

Findings of Fact and Conclusions of Law:

1) Petitioner testified he began working as a sheet metal worker for Respondent in 2003, performing installation of heating and A/C equipment. Petitioner testified that on August 17, 2011, while at a job site at a grade school, he sustained a right elbow and low back injury when he threw a 50 pound extension cord up to his foreman, Paul Tobin, who was up in the ceiling. [13 WC 609]. Petitioner testified he felt a pulling or burning in his right arm and elbow and a twisting injury in his lower back. Petitioner testified that prior to August 17, 2011 he had no right arm or low back treatment or injury. Petitioner testified that following his injury on that date he drove directly to Respondent's shop in Hillside and reported his injury to Mike Crnkovich, the general superintendent. Petitioner testified he returned to work for Respondent thereafter and continued working full duty for Respondent throughout the course of 2011, and into 2012. (T13-22).

2) Petitioner's immediate supervisor, Paul Tobin, testified Petitioner was not working with him on August 17, 2011, that Petitioner was actually kicked off the grade school jobsite due to Petitioner's behavior on August 3, 2011. Tobin testified Petitioner never advised him that he had injured himself at work on August 3, and that Petitioner did not return to the jobsite after being kicked off of it on August 3, 2011. (T73-75). Mike Crnkovich, testified Petitioner never reported an August 17, 2011 work-related injury to him on that date or any other date thereafter. Crnkovich testified that in August of 2011 he had a conversation with Petitioner after he was kicked off the grade school jobsite, and that during that conversation Petitioner made no mention

of any work-related injury, but instead complained about working conditions, and that Petitioner was then placed on a different job project thereafter, at the Dirksen Federal Building. (T88-92).

3) Petitioner admitted he sought no treatment for his alleged right elbow or low back injuries from August 17, 2011. (T45). Petitioner admitted he saw Dr. Riccardo, his personal physician at Westbrook Internal Medicine, for a comprehensive physical on January 30, 2012. At the time of the January 30, 2012 office visit Dr. Riccardo noted all of Petitioner's systems were negative, no joint pain or swelling, no sciatic symptoms, and no low back spinous process tenderness, normal examination of his extremities, and a normal neurological exam. Dr. Riccardo's assessment was anxiety and alopecia. The office note fails to contain any history of Petitioner's alleged August 17, 2011 work injury, of any right elbow or low back injury, or of any right elbow or low back symptoms. (RX1).

4) Petitioner testified that on November 14, 2012 he was working on a project for Respondent at Capital One on Golf Road in Rolling Meadows, performing retrofit heating and A/C work, with a co-worker, Robert Muldoon. Petitioner testified that on that date he was moving pallets of material weighing 400 to 500 pounds with a pallet jack, and while attempting to maneuver the materials he felt a pain in his right elbow and lower back. [12 WC 43353]. Petitioner testified he continued working until his supervisor, Mike Chancellor, called his co-worker, Muldoon, on Muldoon's cell phone at 12:45pm. Petitioner testified he spoke to Chancellor on Muldoon's cell phone and advised Chancellor that he had re-aggravated his right elbow and low back while working. Petitioner testified Chancellor advised him to take a few days off and see how he felt afterward. (T23-29).

5) Petitioner testified that on Sunday, November 18, 2012 at approximately 8:00 p.m. he called Chancellor and advised him that his right arm and back were no better with time off work, and that he had wanted to see a doctor regarding same. Petitioner testified that at that point Chancellor advised him that he was laid off. (T30-31). Petitioner testified that he reported back to the Capital One job site on November 19, 2012, and waited there for eight hours until Crnkovich arrived at the job site and gave him his layoff check. (T30-33).

6) On December 18, 2012, an Application for Adjustment of Claim was filed in 12 WC 43353, alleging an injury to the arm and back on August 24, 2012, with Petitioner's signature having been affixed to the document on November 20, 2012.

7) On November 21, 2012 Petitioner sought treatment with Dr. Hsu at Westbrook Internal Medicine, at which time he reported he reinjured his back and right elbow on November 14, 2012, and that he had sustained a prior low back and right arm injury in August of 2011 when he threw 100 feet of cable to someone above him. [Companion Case 13 WC 609]. At the time of the November 21, 2012 office visit Petitioner complained of low back pain and right arm pain. Petitioner further reported that he had been taking Aleve four times a day for his low back symptoms since his prior injury in August of 2011 without resolution of symptoms. Dr. Hsu diagnosed back pain and right elbow pain/strain, referred Petitioner to physical therapy, and

advised Petitioner x-rays and an orthopedic referral would be made if he failed to improve. (PX1).

8) On November 29, 2012, Petitioner sought treatment with Dr. Freedberg at Suburban Orthopaedics, at which time Petitioner provided a history that he pulled his right arm and low back while moving material with a pallet jack. Dr. Freedberg's assessment was a lumbar sprain/strain with left SI joint dysfunction, grade 1 spondylolisthesis at L5-S1, and right elbow lateral epicondylitis with brachialradialis strain. Dr. Freedberg recommended physical therapy and MRI scans of the lumbosacral spine and right elbow, and authorized Petitioner off work. (PX2). On cross-examination Petitioner admitted that he advised Dr. Freedberg at his November 29, 2012 office visit that he had been having elbow and back pain for well over a year. (T56).

9) On December 3, 2012, Petitioner underwent an MRI study of the lumbar spine, significant for spondylolysis at L5 and right foraminal herniation and a diffuse bulge at L2-3, and an MRI study of the right elbow, significant for a radial collateral ligament tear and partial-tear of the common extensor tendon. (PX3).

10) On December 10, 2012 Petitioner was seen in follow up with Dr. Freedberg, at which time he reported constant burning, numbness, and tingling in his elbow, as well as constant backaches. Dr. Freedberg recommended Petitioner remain off work, continue physical therapy, and consider right elbow surgery. (PX2).

11) On January 9, 2013, Dr. Freedberg performed right elbow surgery, with right elbow debridement of the extensor carpi radialis brevis and decortication of the bone, repair of the extensor mechanism, and imbrication of the posterior anterior capsule and radial collateral ligament. Petitioner's post operative diagnosis was right elbow lateral epicondylitis with mild laxity of the posterolateral corner. (PX4).

12) Petitioner was seen in follow up on January 24, 2013, February 25, 2013, and on April 10, 2013, during which time Petitioner underwent a course of physical therapy, remained off work, and reported improvement in his right elbow symptoms but continuing symptoms in his low back. (PX2).

13) On April 10, 2013 Dr. Freedberg recommended Petitioner remain off work, continue physical therapy for Petitioner's low back and right elbow, and referred him to Dr. Novoseletsky for consultation and possible lumbar injections. (PX2). Petitioner testified he was seen by Dr. Novoseletsky on April 17, 2012, but that he had not undergone any low back injections to date. Petitioner testified he was last seen by Dr. Freedberg on May 8, 2013, that he was still undergoing physical therapy three times a week, and that his elbow was improving. Petitioner testified he was authorized off work by Dr. Freedberg from November 29, 2012 through the date of hearing. (T34-39).

Although the Arbitrator found, with regard to Petitioner's alleged November 14, 2012 right elbow injury, that Petitioner had failed to meet his burden of proof concerning the issues of accident, notice, causal connection, and temporary total disability, the Commission finds otherwise. The Commission finds that on November 14, 2012 Petitioner sustained an accidental injury arising out of and in the course of his employment with regard to his right elbow, that his current right elbow condition is causally connected to said accident, that Petitioner provided timely notice as required under Section 6(c), and that Petitioner was temporarily totally disabled with regard to his right elbow condition from November 29, 2012 through the date of 19(b) hearing, May 17, 2013.

On January 30, 2012, Petitioner underwent a comprehensive physical with his personal physician, Dr. Riccardo. Petitioner's physical examination was essentially normal, and the assessment made by Dr. Riccardo was limited to anxiety and alopecia. The January 30, 2012 office note contains no complaint with regard to Petitioner's right elbow. The Commission transcript further contains no evidence of any right elbow medical treatment or any surgery recommendation in the years preceding the date of injury. The Commission finds significant that Petitioner testified, unrebutted, that prior to his November 14, 2012 work injury he received no medical treatment with regard to his right elbow. The Commission is also persuaded by the fact that Petitioner, a 45 year-old on the date of injury, worked full duty as a sheet metal worker for Respondent from 2003 up until time of his November 14, 2012 work injury, and that the record is void of any evidence of lost time due to any right elbow complaints during that period.

The Commission is cognizant that both Dr. Hsu and Dr. Freedberg's office notes as they indicate they were treating Petitioner for pain in his right elbow due to a work related injury. On November 29, 2012 Dr. Freedberg issued a work duty status form authorizing Petitioner off work due to a work related injury. The Commission finds significant the December 3, 2012 right elbow MRI findings indicating significant findings of a radial collateral ligament tear and partial-tear of the common extensor tendon. The Commission notes the record is void of a medical expert's opinion disputing the issue of causal connection between Petitioner's current right elbow condition and his November 14, 2012 work-related injury or right elbow MRI findings.

For the reasons stated above, the Commission finds Petitioner sustained accidental injuries, with regard to his right elbow, arising out of and in the course of his employment on November 14, 2012, and that his current right elbow condition of ill-being is causally related to same.

With regard to the issue of notice, the Commission finds Petitioner provided timely notice of his November 14, 2012 right elbow injury based upon his credible testimony on the issue. Petitioner testified that during the course of Mike Chancellor's November 14, 2012 cell phone call to his co-worker, Muldoon, he participated in the phone call and specifically advised Chancellor that he re-aggravated his right elbow during the course of the day. Petitioner testified Chancellor advised him to take a few days off, after which Petitioner contacted Chancellor on

Sunday, November 18, 2012 and advised that his right elbow had not improved and he needed to seek medical treatment for same.

Based upon the finding of causal connection with regard to Petitioner's right elbow condition herein, the supporting medical records, and the off work authorizations, the Commission finds Petitioner was temporarily totally disabled for a period of 24-1/7 weeks, from November 29, 2012 through the date of 19(b) hearing, May 17, 2013, at $1,084.93 per week under Section 8(b).

Although the Commission finds Petitioner proved he sustained an accidental injury arising out of and in the course of his employment on November 14, 2012 with regard to his right elbow, with regard to Petitioner's low back condition the Commission affirms and adopts the Arbitrator's finding that Petitioner failed to prove his low back condition of ill-being is causally related to his November 14, 2012 work-related injury. In so finding, the Commission finds Petitioner's testimony and the history he provided to his medical providers following his November 14, 2012 work injury less than credible with regard to his low back condition. The Commission notes that on November 21, 2012, Petitioner provided a medical history to his personal physician, Dr. Hsu, that in the year prior to his November 14, 2012 work injury he suffered from low back complaints requiring him to take four Aleve each day, without resolution of his symptoms. The Commission finds Petitioner's history of having low back pain for a year requiring him to take four Aleve each day highly suspect given that Petitioner worked full duty as a sheet metal worker for Respondent following an alleged injury of August 11, 2011 up until time of his November 14, 2012 work injury. Furthermore, the January 30, 2012 office visit note of Dr. Riccardo, at which time Petitioner was underwent a comprehensive physical, noted all of Petitioner's systems were negative, with no joint pain or swelling, no sciatic symptoms, and no low back spinous process tenderness, normal examination of his extremities, and a normal neurological exam. Dr. Riccardo's assessment on that date was limited to anxiety and alopecia. The office note failed to contain any history of Petitioner's alleged August 17, 2011 work injury, of any ongoing low back condition, low back symptoms, or of Petitioner taking four Aleve a day for any ongoing low back symptoms. In addition, Dr. Riccardo's listing of Petitioner's current medications failed to reflect "Aleve" or any other similar medication as of that January 30, 2012 office visit. (RX1). Petitioner also admitted at the time of hearing that he provided Dr. Freedberg with a similar history of low back pain for well over a year as of his initial office visit with him on November 29, 2012. The Commission finds Petitioner's medical records fail to corroborate his history of ongoing low back symptoms following his August 11, 2011 alleged incident, and that Petitioner's testimony as to a new low back injury is also not credible.

With regard to Petitioner's request for a prospective medical award for his low back condition, based upon the Commission's finding of no causal connection with respect to same, the issue is moot.

With regard to the issue of penalties and fees based upon non-payment of temporary total disability benefits, the Commissions declines to award same, and finds a real controversy exists as to whether or not Petitioner's current condition of ill- being is causally related to his work

accident. The Commission further finds Respondent behavior was not unreasonable nor did Respondent's action result in vexatious delay or intentional underpayment of benefits.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed March 13, 2013 is hereby reversed with regard to Petitioner's right elbow condition of ill-being, for the reasons stated herein, and affirmed and adopted with regard to Petitioner's low back condition of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,084.93 per week for a period of 24-1/7 weeks, from November 29, 2012 through May 17, 2013, 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 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 $26,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 5 - 2015
KWL/kmt
R-05/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JANINA LISKOWIAK, widow of
ZBIGNIEW LISKOWIAK, Deceased,

Petitioner,

15IWCC0607

vs.

NO: 11 WC 003046

PRESTIGE DECORATING,

Respondent.

ORDER ON REMAND

This matter is again before the Commission pursuant to the September 17, 2014, Opinion and Order of Judge Carl Anthony Walker of the Circuit Court of Chicago. Said Opinion and Order requests of the Commission to explain its March 26, 2013, Order, an order in which $33,934.26 was awarded as attorney's fees. Given the limited scope of the Opinion and Order and noting the accurate recitation of the factual and procedural histories in this matter, the Commission declines to repeat said histories in this Order on Remand. The Commission, instead, limits its Order on Remand to explain its rationale with respect to the awarded attorney's fees.

Petitioner Janina Liskowiak ("Liskowiak") entered into an Attorney Representation Agreement with Bellas & Wachowski ("Wachowski") on January 12, 2011, with Peter C. Wachowski signing on behalf of Wachowski, to prosecute her claim against Respondent Prestige Decorating ("Respondent") with respect to the injuries her late husband, Zbigniew Liskowiak, sustained on November 11, 2010. The terms of compensation are codified in the Act and were reproduced in the controlling Attorney Representation Agreement as noted below:

In return for representation before the Commission, the client agrees to pay the attorney a sum of money equal to:

A. 1. 50% of any amount received in excess of the written offer, if any, or 20% (not to exceed 20%) of the total amount received for compensation for permanent disability caused by the accident, whichever is less; provided, however, if the compensation received for permanent disability does not exceed the written offer, the attorney shall receive no fee for permanent disability; or

2. $100.00 (not to exceed $100) if the respondent does not dispute its liability, the proper amount is paid timely, the client does not receive more than that specified by law, and the accident resulted in any of the following: death of the employee; amputation of one or more fingers, toes, or body parts; removal of a testicle; enucleation or 100% loss of vision in an eye; fracture of one or more vertebra, spinous or transverse process, or facial bones; fracture of a skull; removal of a kidney, spleen, or lung; and

B. 20% (not to exceed 20%) of any compensation for temporary total disability that the employer refused to pain in a timely manner or in the proper amount; and

C. 20% (not to exceed 20%) of all disputed medical bills; and

D. In addition to the above, all costs and expenses of advocating the above claim.

No settlement shall be made without the consent to the client. There will be no charge unless recovery is made.

If the client terminates this agreement before recovery, the client will pay the attorney for a reasonable fee, as determined by the Illinois Workers' Compensation Commission, from the subsequent recovery (not to exceed the amounts listed in A-C above) plus any unpaid expenses related to advocating the claim up to the date the agreement ended.

Both Liskowiak and Wachowski cite paragraph A as containing the controlling language in this matter, with Liskowiak relying on paragraph A2 and Wachowski relying on paragraph A1. The Commission finds it is not a matter of finding one paragraph more applicable than another. Rather, the Commission finds paragraph A1 to be applicable and paragraph A2 to not be applicable.

Paragraph A2 stipulates that an attorney's compensation is to be capped at $100.00 in situations in which the respondent does not dispute its liability and the accident resulted in the death of an employee. It is noted in paragraph A2 the word "and" is used as a conjunction, indicating there has to be both no dispute as to liability and the death of an employee for the compensation limit as set forth in paragraph A2 to become operative. It is further noted that a

15IWCC0607

dispute of liability is not limited to a defined issue. Accordingly, the Commission finds a respondent contesting any issue is sufficient to make paragraph A2 inoperative. In the present matter, it is noted in both the Request for Hearing as well as the Arbitration Decision filed with the Commission on September 24, 2012, that liability for unpaid medical bills was an issue Respondent contested, with the Arbitration Decision stating, "The respondent disputed and contested liability, and did not pay any benefits until August 2012." The Commission, therefore, finds paragraph A2 to be inoperative due to Respondent disputing liability.

Respondent disputed liability and, as a result, paragraph A1 came into effect. There is no evidence of or claim made that a written settlement offer was tendered by Respondent to Liskowiak. Thus, the Commission does not entertain the provision within paragraph A1 in which that scenario is discussed. The absence of a written offer leaves only the provision contained within paragraph A1 of "20% of the total amount received for compensation for permanent disability caused by the accident . . ." as the only means to determine a proper amount of compensation. The Commission, however, notes claims involving death cases, the compensation is not the stipulated 20% of the total amount received for compensation. Section 16a of the Act sets forth, "in death cases . . . the amount of an attorney's fees shall not exceed 20% of the sum which is due under this Act for 364 weeks of permanent total disability based upon the employee's average gross weekly wage prior to the date of the accident . . . unless further fees shall be allowed to the attorney upon a hearing by the Commission fixing fees." 820 ILCS 305/16a (2013).

Applying the formula as set forth under Section 16a, the Commission finds the proper compensation to Wachowski to be $33,934.26. The decedent's gross average weekly wage, as stipulated, was $520.00. The compensation rate, per Section 8(f), would leave a compensation amount below the statutory minimum compensation rate for accidents involving deaths occurring in 2010. The statutory minimum compensation rate for such accidents is $466.13 per week. As the Act limits attorney compensation in death cases to 20% of the sum which is due under this Act for 364 weeks, $466.13 is multiplied by the statutorily-prescribed 364 weeks and results in a sum $169,671.32. Twenty percent of that amount is $33,934.26.

Per the record, liability was an issue resolved only by the September 24, 2012, Arbitration Decision. Contained within said decision was an award with respect to the contested issue. The Commission, accordingly, finds Wachowski successfully represented Liskowski's interests and merits the compensation as permitted under the Act, as defined in the executed January 12, 2011, Attorney Representation Agreement and as awarded by the Arbitration Decision.

IT IS HERE BY ORDERED BY THE COMMISSION that Liskowiak pay to Wachowski the attorney's fees as awarded in the September 24, 2012, Arbitration Decision;

15IWCC0607

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to reissue the check originally issued on August 7, 2012, in the amount of $49,951.70 to allow for disbursement to Wachowski;

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to pay to Wachowski twenty percent (20%) of all payments previously made to Liskowiak; and

IT IS FURTHER ORDERED that Respondent shall cause its workers' compensation insurance carrier to pay all future attorney's fees related to this matter directly to Wachowski.

DATED: AUG 5 - 2015
KWL/mav
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tawanda Kelly,

Petitioner,

vs.

NO: 12 WC 3858

Bridgeway Christian Village,

15IWCC0608

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Petitioner and Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, extent of temporary total disability, medical expenses 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 modifies the Arbitrator's Decision regarding the issue of accident finding that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on December 13, 2011. Petitioner testified that on December 13, 2011, she was working the 3:00 p.m. to 11:00 p.m. shift. According to Petitioner, during her shift a co-worker named Mame asked Petitioner to help her reposition one of her female patients. Petitioner testified that she and Mame went into the patient's room. On the count of three, they were supposed to lift the patient up. However, on the count of three, Mame did not move, but Petitioner did and threw herself over the patient. At that time Petitioner was hurt, so she laid on the patient for a few minutes and then left the room. Her low back hurt at that time. Petitioner testified that she had a little bit of pain for the rest of her shift. On cross-examination, Petitioner testified that as she left the room, another co-worker jumped on her back, but that her back pain

was the same after being jumped on as it had been after the lifting incident. Petitioner testified that the next day, December 14, 2011, she was feeling okay when she got to work about 3:00 p.m. About 5:00 p.m., Petitioner was sitting down in a room watching dementia patients. When she tried to get up, Petitioner was in so much lower back pain that she could not move to get up. Petitioner testified that she notified her supervisor and was sent by cab to the company clinic, St. Alexius, where she stated she was examined, given medications and light duty work was recommended. The Commission notes that there are no records from a St. Alexius in evidence. However, there are records from Alexian Brothers Corporate Health Services dated December 14, 2011 at 5:46 p.m., which note a date of onset as December 13, 2011 at 7:00 p.m. and the following history: "Pulling up 200 lb resident and fell on top of patient. 1 hour later felt lower back pain. Now pain down left leg and going up left arm. Numbness and tingling." There are also records from the Addison Fire Department dated December 14, 2011 at 11:47 p.m., which state: "Pt. stated she was walking at work and felt a sudden sharp pain in her back. Pt. denied any trauma." Petitioner was taken to Elmhurst Memorial Hospital emergency room where she reported the following history: "It started about 29 hours ago while she was just walking. She denies any known injury."

In the December 14, 2011 Witness Report, Mame Serwaa indicated she knew nothing about the December 13, 2011 incident and that she was not present when the incident happened. Ms. Serwaa indicated that Petitioner told her that she did one resident named Michael by herself and might have pain from that. The Commission finds that this is contrary to Petitioner's testimony that Mame was helping her lift a female resident, that Mame did not pull up her side and all the resident's weight was on her and she collapsed on top of the resident and laid there a few minutes. The Commission finds that Petitioner's testimony about the accident is contradicted by the Witness Report of co-worker Mame Serwaa. The Commission also finds that the histories given by Petitioner to the initial treaters are different than her testimony. There are two histories Petitioner gave to the company clinic Alexian Brothers Corporate Health Services: 1) that on December 13, 2011 she was pulling up a patient and 2 hours later felt back pain and 2) that on December 13, 2011 she was pulling up 200 pound resident and fell on top of patient and 1 hour later felt lower back pain. That same day hours later, Petitioner reported to the Addison Fire Department ambulance EMT that she was walking at work and felt a sudden sharp pain in her back and denied any trauma. Petitioner then reported to Elmhurst Memorial Hospital emergency room that her pain started about 29 hours ago while she was just walking and denied any known injury. Based on the above, the Commission finds that Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on December 13, 2011. The Commission affirms all else, including the Arbitrator's finding of no causal connection. The Commission notes that there is no remand to the Arbitrator for further hearing as Petitioner's claim is denied.

IT IS THEREFORE ORDERED BY THE COMMISSION that since Petitioner failed to prove she sustained accidental injuries arising out of and in the course of her employment on December 13, 2011 and failed to prove that a causal relationship exists, her claim for compensation and medical expenses is hereby denied.

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

DATED: AUG 5 - 2015
MB/maw
o07/09/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

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

KELLY, TAWANDA
Employee/Petitioner

Case# **12WC003858**

BRIDGEWAY CHRISTIAN VILLAGE
Employer/Respondent

15IWCC0608

On 12/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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0522 THOMAS MAMER & HAUGHEY LLP
ERIC CHOVANEC
P O BOX 560
CHAMPAIGN, IL 61824

15IWCC0608

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Tawanda Kelly
Employee/Petitioner

v.

Bridgeway Christian Village
Employer/Respondent

Case # **12** WC **3858**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton**, on **November 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[x] 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 13, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did*** 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 $**15,403.57**; the average weekly wage was $**331.72**.

On the date of accident, Petitioner was **38** years of age, ***single*** with **2** dependent children.

Respondent ***is not liable for*** reasonable and necessary medical services.

Respondent shall be given a credit of $**N/A** for TTD, $**00.00** for TPD, $**N/A** for maintenance, and $**00.00** for other benefits, for a total credit of $**00.00**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

The petitioner has demonstrated the occurrence of an accident; however, for reasons set forth in the attached decision, her current condition of ill-being is not related to the accident. Benefits under the Act are denied.

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

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

Signature of Arbitrator

December 22, 2014
Date

ICArbDec19(b)

DEC 22 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TAWANDA KELLY,	)	**15IWCC0608**
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 03858**
	)	
BRIDGEWAY CHRISTIAN VILLAGE,	)	
	)	
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Sections 8(a) and 19(b) of the Act.

STATEMENT OF FACTS

The petitioner was employed as a CNA by the respondent, a rehabilitation and nursing home. Her job duties included assisting patients with daily living activities, and she worked the 3 P.M. to 11 P.M shift. She began working for the respondent in late 2010 or early 2011, about one year prior to the date of loss at issue.

The petitioner testified that at about 8:30 P.M. on December 13, 2011, a co-worker asked for help repositioning a heavy patient. The petitioner testified that while attempting to lift the patient, the petitioner felt immediate pain in the low back. The petitioner fell across the patient, laid there briefly, then left the room. She testified she felt immediate pain that receded and then spiked the next day. She testified at that point she took a cab to Alexian Brothers.

The medical records show that at about 6:45 P.M. on December 14, 2011, she presented at Alexian Brothers Medical Center. She reported a low back injury which occurred at 7 P.M. the day before. She reported a history of pulling up a resident and fell atop the patient, but that pain in her low back did not occur until one to two hours after that. She reported current symptoms in her low back, left leg and left arm. X-rays noted degenerative changes without bony pathology. She was diagnosed with a lumbar sprain/strain at that point and given Naproxen. PX2.

At approximately 11:45 P.M. on December 14, 2011, an ambulance was dispatched to the petitioner's home. The EMT narrative noted the petitioner was lying on the bed in obvious pain. The petitioner's family stated she had pinched a nerve at work and had taken ibuprofen. The petitioner told the EMTs she had been walking at work and felt a sudden sharp pain in her back, and denied any trauma. She was taken by ambulance to Elmhurst Hospital, arriving there at about 12:30 A.M. on December 15,

2011. See PX1.

The records at Elmhurst Memorial hospital demonstrate that she was seen at about 12:30 A.M. for complaints of severe left lower back pain radiating down the left leg. She reported it had begun 29 hours before "while she was just walking." She denied any known injury. Handwritten notes in the intake report also note no trauma. See PX3. She was given morphine and discharged with instructions to see her primary care doctor or an orthopedist. PX3. On December 27, 2011, she secured additional medications, but no version of accident is noted. PX3.

The petitioner returned to Elmhurst Memorial Hospital on January 20, 2012. She complained of left sided spasm with pain in the arm and reported a history of low back pain which had "noted improvement until tonight." It was noted the mechanism of injury was "atraumatic" and had begun while she was sleeping. See PX3.

On January 23, 2012, the petitioner saw Dr. Stallings, complaining of low back pain with radiation down her left leg to her foot. He noted no history of any recent back or leg injuries, and she reported having had this pain intermittently for six months with it having worsened over the last two weeks. See PX4. He assessed her with lumbago, and prescribed medication and an MRI. PX4.

The petitioner had a lumbar MRI on January 26, 2012. It noted disk bulging at L4-5 with narrowing of the nerve roots at that level. PX4, PX9. On January 30, 2012, Dr. Stallings reviewed the MRI and recommended the petitioner see an orthopedist. PX4.

The petitioner saw Dr. Mitchell Goldflies, an orthopedist, on February 4, 2012. The petitioner reported lifting a patient on December 11, 2011. Dr. Goldflies assessed her with lumbar radiculopathy and recommended physical therapy and medication. PX5, PX9. He maintained her in therapy on February 18, 2012. PX5.

On March 16, 2012, the petitioner was seen by Dr. Chunduri at St. Anthony's Hospital. PX9. Dr. Chunduri provided an epidural injection on March 23, 2012. PX9, PX10. On March 30, 2012, Dr. Chunduri noted no relief from the injection and recommended medication management with a follow-up in a month. See PX9.

On May 11, 2012, the petitioner was seen by Dr. Gunnar Andersson pursuant to Section 12 of the Act. Dr. Andersson noted he did not have the imaging reports or Dr. Stalling's reports. She advised Dr. Andersson that she had a stroke in late February 2012 and provided him a CT scan and MR angiogram of the head, which left her with right leg weakness. See RX1. Dr. Andersson thereafter received and reviewed the objective study films. In a supplemental report, he noted degenerative changes which certainly preceded the date of December 13, 2011. He noted if the history of incident as she described was accurate, it could have aggravated her condition, but noted that her history that she provided to Elmhurst Hospital suggested no such incident took place. He opined she could benefit from an FCE, but any restrictions would not be related to work. See RX2.

On June 1, 2012, Dr. Chunduri saw the claimant. She reported no improvement. He modified her medications and recommended physical therapy and chiropractic care as well as an EMG study. PX9. The EMG study was performed on July 7, 2012. It suggested L5-S1 radiculopathy and early axonal neuropathy. PX9. On July 13, 2012, Dr. Chunduri saw the petitioner. He recommended an epidural injection, noting that if relief was not obtained he would recommend a neurosurgical evaluation. PX9.

On September 21, 2012, Dr. Chunduri noted that the petitioner was reporting that her pain had become intermittent following the first epidural injection. He recommended another injection. PX9. On October 8, 2012, the petitioner underwent an L4-5 epidural steroid injection from Dr. Chunduri. PX6, PX10. In a follow-up on October 18, 2012, the petitioner noted no improvement from the injection, and Dr. Chunduri recommended physical therapy and medication. PX10.

On December 13, 2012, the petitioner told Dr. Chunduri that her pain improved following the second injection but had recurred. Dr. Chunduri recommended a lumbar discogram. PX10. On December 17, 2012, the petitioner underwent a discogram and post-discogram CT scan. The discography report notes concordant pain at L4-5 and the CT scan assessed her with an L4-5 disk herniation. See PX6, PX7, PX8, PX10.

On January 24, 2013, Dr. Chunduri saw the petitioner. She continued to report pain in her back and weakness in her right leg. Dr. Chunduri recommended a neurosurgical referral. Dr. Chunduri continued refilling medications and referring her to a neurosurgeon on an approximately monthly basis thereafter. PX10.

On February 24, 2014, the petitioner underwent another epidural steroid injection by Dr. Chunduri. PX10, PX12. On April 4, 2014, she reported no improvement. Dr. Chunduri recommended that she see a neurosurgeon and refilled her medications. He renewed those prescriptions on June 27, 2014. See PX10.

On July 28, 2014, the petitioner saw Dr. Salehi, a neurosurgeon. She reported an accident in December 2011 with no symptoms prior to that date of loss. He assessed disk degeneration with lumbar radiculopathy and recommended new imaging studies. PX11. On August 14, 2014, the petitioner underwent a new MRI scan. It noted spondylotic changes at L4-5 with a broad-based protrusion and stenosis at that level. PX14. On August 21, 2014, Dr. Salehi saw the petitioner and reviewed that MRI. He assessed annular tearing and disk disease, and recommended L4-5 fusion surgery. PX11.

Dr. Chunduri saw the petitioner on September 19, 2014. He refilled her medications and instructed her to follow up with her spine surgeon. PX13.

On October 30, 2014, Dr. Andersson reviewed the additional medical records since his initial examination of the claimant and authored another Section 12 report. He again noted that he was not of the opinion that an acute incident happened. However, he also noted that the newer findings on the more recent MRI were suggestive of a natural degenerative process which was already transpiring as of December 2011, which is what

would have been expected, and opined that the petitioner's condition was not permanently aggravated by any incident that day. He believed the surgery proposed was not unreasonable but was not related to any workplace accident. See RX3.

The respondent introduced records from the petitioner's current employer; among these records are annual certifications from 2009 through the present signed by her primary care provider, Dr. Stallings. They aver that the petitioner is healthy and fit for duty. See RX4.

The petitioner filled out a report of incident on December 14, 2011, which states that she and a co-worker named Mame pulled up a resident but the sheet was not correctly placed. The petitioner then says at the end of the shift, a co-worker tried to hug her and worsened the pain. See RX5. However, a written statement by her co-worker, Mame Serwaa, states that she knows nothing about any asserted incident and was not present when anything occurred; the date of this written statement is partially obscured, but appears to be December 14, 2011. See RX6. Ms. Serwaa further wrote that the petitioner told her that she (the petitioner) had worked with one resident named Michael alone. Ms. Serwaa speculated that might have caused the injury, but the petitioner did not tell her that that was what in fact had occurred. Even setting aside the speculative nature of that aspect of the report, the Arbitrator does note the petitioner specifically testified that the patient being worked with at the time of the asserted injury was female.

The petitioner has continued to work as a CNA and behavioral counselor for a different employer, Maxim Healthcare Services, with whom the petitioner had worked before the date of loss as well. See PX16, RX4. She testified to constant residual discomfort and expressed a desire to have the surgery proposed by Dr. Salehi.

ANALYSIS, OPINION AND ORDER RELATIVE TO DISPUTED ISSUES

Accident

A claimant must first demonstrate by the preponderance of credible evidence that an injury arose out of and was in the course of employment in order to receive compensation under the Act. See, e.g., *Orsini v. Industrial Commission*, 117 Ill.2d 38, 44-45 (1987). The Arbitrator finds significant areas of concern regarding a demonstration of accidental injury.

The petitioner's testimony was in direct contradiction to the witness statement prepared by her co-worker, Mame Serwaa, whom the petitioner identified as being physically present at the time of the injury. RX6. Moreover, the petitioner's history of complaints differs from the medical providers – she testified as to immediate pain, but the Alexian Brothers report notes it took at least an hour before the pain set in. PX2. When the ambulance arrived at her home late on December 14, 2011, her family only told the EMTs that she had suffered a pinched nerve while she had been at work, but did not relate any circumstance of how her injury happened. And the petitioner, at that time and

requesting emergency care, specifically stated that she had been walking and felt a sudden pain, and did not report any history of pulling or lifting a patient to the EMTs. See PX1. Her presentation at Elmhurst Memorial Hospital on December 15 does show that she told a nurse about moving a patient, but did not tell the doctor that, and she was noted to have no history of trauma. PX3. Moreover, when she saw Dr. Stallings, at a different facility, he took a detailed history of her symptoms and specifically noted no traumatic occurrence or onset. PX4.

At trial, the petitioner attempted to dispute Dr. Stalling's recorded history in the January 23, 2012 presentation. She testified that she had a prior history of upper back pain, but the low back pain was new, and asserted Dr. Stalling's records were wrong. The Arbitrator is unsatisfied by this argument; Dr. Stalling was quite clear that it was the specific low back pain of which the claimant was currently complaining that had persisted for six months without specific prompting.

The petitioner's rendition of events may well have been embellished – the petitioner describes it as literally collapsing in pain across the patient she was aiding and requiring time to collect herself – but the activity she reports performing is consistent with her usual and expected job duties. The respondent's suspicions are certainly understandable given both the discrepancies in the witness statement and the medical records noted above. Moreover, such a dramatic incident would have been much more likely to be recalled by her coworker, or reported that same day.

Had the claimant not specifically discussed moving a patient with the first provider (Alexian Brothers) the Arbitrator would certainly conclude the claimant had failed to credibly demonstrate a workplace accident. However, given that specific documentation, and noting the guidance of the Illinois Supreme Court in *Shell Oil v. Industrial Commission*, 2 Ill.2d 590 at 602 (1954), where it was noted "it is presumed that a person will not falsify such statements to a physician from whom he expects and hopes to receive medical aid," the Arbitrator does find sufficient evidence to corroborate an accidental injury.

Causal Relationship

Having noted that, the Arbitrator finds that the petitioner's current condition of ill-being is not causally related to any incident in December 2011. While the petitioner has continued asserting that incident to her current treating providers, it is notable that she did not mention her symptoms having receded before aggravating her condition on January 20, 2011, due to an awkward sleeping position. Dr. Stallings' records clearly demonstrate a much longer history of symptoms that the petitioner is willing to admit at trial or to her current treating providers. And while Dr. Andersson does appear to have lacked some of the medical records in rendering his opinion, he does note the progression of her condition on MRI study and credibly concludes that in all likelihood she had a natural and degenerative condition and any injury in December 2011 would only have temporarily aggravated it. This is consistent with her having denied any significant

trauma to the EMTs and at Elmhurst Hospital – that the December 2011 incident was in truth a minor event which did not materially alter the progression of her condition.

Medical Services, Prospective Medical Care, and Temporary Partial Disability

Medical expenses incurred, prospective medical services, and disability benefits are not causally related, and are accordingly denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Andre Howliet,
Petitioner,

vs.

NO: 10 WC 31447

15IWCC0609

City of East St. Louis Fire Department,
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 causation, temporary total disability and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found Petitioner is entitled to the following medical bills: PX3, 5, 9 through October 11, 2010 along with PX12 and 14 so long as they are subject to the fee schedule.

The Commission has reviewed the three exhibits in which Respondent claims that there were medical expenses awarded for conditions not related to the July 15, 2010 work accident.

In regard to PX9, the Commission did not find an October 11, 2010 entry for the hypertensive chronic kidney disease. Rather, the evidence indicates that the medical charge for the October 11, 2010 was for a limited office visit. In looking at the medical entry for October 11, 2010 contained in Petitioner's PX8 the primary reason listed for the visit was for medical clearance prior to the right shoulder surgery that was scheduled for the next day. There is no mention of hypertensive chronic kidney disease. As such, the Commission finds that this medical bill was for a valid service related to Petitioner's claim and affirms the Arbitrator's award of the same.

In regard to PX3, the Commission found when the bills for the July 15, 2010 hospitalization and the physical therapy services are totaled they equal the requested $18,346.00 Petitioner is seeking for PX3. Additionally, the Commission found a medical bill for January 16, 2012 (not January 6, 2010 as noted in Respondent's brief) is contained in the exhibit. It appears that a bill for January 16, 2012 is not related to nor is it being asked to be awarded as part of PX3. As such, while the Commission finds that the January 16, 2012 bill should not be part of PX3, it is also a bill for which Petitioner is not seeking payment of in regard to the claim.

In regard to Petitioner's PX5, the chest CT bill, the Commission did not find corresponding documentation in PX4 to indicate that this bill should have been awarded. As such the Commission vacates any medical award related to PX5.

The Commission finds that on page 12 of the Arbitrator's decision there is a misstatement of the facts. Specifically the Arbitrator states that "Respondent's exhibit 5 indicates that Petitioner was, for the final 27 weeks of his off-work time, required to use sick time and vacation time in ordered to be paid for his time away from work (Respondent's Exhibit 5)." This statement should have indicated 18-4/7 weeks and not 27 weeks.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $756.17 per week for a period of 70-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Respondent shall receive a credit for any salary paid to Petitioner during this time.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 80.06 weeks, because the injuries sustained caused the 2% loss of use of the right arm (for the right elbow) and 15% man as a whole (for the shoulder injury) as provided in §§8(e) and 8(d)2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the reasonable and necessary medical expenses set forth in PX3 and 9 (only through October 11, 2010), 12 and 14 subject to the medical fee schedule and with Respondent receiving full credit pursuant to the Stipulation of the Parties. To the extent any bills have been paid by Petitioner's group medical plan for which credit is allowed under §8(j) of the Act, Respondent shall hold Petitioner harmless from the same. The Commission vacates the medical award for PX5.

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.

15IWCC0609

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

DATED: AUG 6 - 2015

MB/jm

O: 7/15/15

43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HOWLIET, ANDRE
Employee/Petitioner

Case# **10WC031447**

CITY OF EAST ST LOUIS FIRE DEPT
Employer/Respondent

15IWCC0609

On 12/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1221 REED & BRUHN PC
EARL HUBBS
6464 W MAIN ST SUITE 1B
BELLEVILLE, IL 62223

5196 CLAYBORNE SABO & WAGNER LLP
JENNIFER L BARBIERI
525 W MAIN ST SUITE 105
BELLEVILLE, IL 62220

15IWCC0609

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

Andre Howliet
Employee/Petitioner

v.

City of East St. Louis Fire Department
Employer/Respondent

Case # 10 WC 031447

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Collinsville**, on **October 23, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/15/2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**91,355.16**; the average weekly wage was $**1,148.90**.

On the date of accident, Petitioner was **48** years of age, ***married*** with **4** 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 $**35,144.36** for medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$756.17/week** for **70 4/7 weeks**, commencing **9/23/10** through **1/30/12**, as provided in Section 8(b) of the Act. Respondent shall receive credit for any salary paid to Petitioner during that time.

Respondent shall pay Petitioner permanent partial disability benefits of **$669.64/week** for **80.06 weeks**, because the injuries sustained caused the **2 %** loss of use of the right arm (for the right elbow) and **15 %** Man as a Whole (for the shoulder injury) as provided in Sections 8(e) and 8(d) 2 of the Act.

Respondent shall pay the reasonable and necessary medical expenses set forth in PX 3, 5, 9 (only through 10/11/10), 12 and 14 subject to the medical fee schedule and with Respondent receiving full credit pursuant to the Stipulation of the Parties. To the extent any bills have been paid by Petitioner's group medical plan for which credit is allowed under Section 8(j) of the Act, Respondent shall hold Petitioner harmless from same.

Respondent shall pay compensation that has accrued between 7/15/10 and 10/23/14 and shall pay the remainder of the award, if any in weekly installments.

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

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

Nancy Lindsay
Signature of Arbitrator

December 17, 2014
Date

DEC 22 2014

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This case proceeded to arbitration on October 23, 2014 with Respondent disputing causal connection, medical expenses, temporary total disability benefits, and the nature and extent of Petitioner's injury. Petitioner, Monica Grandview, and Jason Blackman testified at the hearing. Having considered all of the evidence presented, the Arbitrator renders the following findings of fact and conclusions of law.

The Arbitrator finds:

Petitioner has been employed with Respondent since 2000. He has held the positions of firefighter, Lieutenant, and Captain.

Petitioner's medical records from his primary care physicians, Drs. Abel and Wolff, were admitted as PX 8. Of note, Petitioner was seen by his doctor on March 2, 2009 after his estranged wife broke into his house and struck him with a wooden table leg on the left parietal scalp. Initial swelling had subsided with ice. The doctor described Petitioner's injury as a minor injury to the scalp. (PX 8)

Petitioner had an appointment scheduled with Dr. Abel for June 30, 2010. It was cancelled and rescheduled for July 7, 2010. (PX 8)

Petitioner presented to Dr. Abel on July 7, 2010 on an "urgent" basis complaining of right shoulder and low back pain. According to the history Petitioner had strained his right shoulder one week earlier but could not recall what the activity was that caused it; however, when raising his right shoulder it was mildly uncomfortable. Petitioner had not taken any medication. Petitioner was diagnosed with a right shoulder strain which Dr. Abel felt would probably resolve itself within a week or so. Petitioner's right shoulder deltoid was mildly tender on the right. He was to use Tylenol as needed for his shoulder. (PX 8, p. 85)

On July 15, 2010, Petitioner was in the course of his employment with Respondent fighting a house fire when the second floor collapsed causing him to fall. Accident was not disputed.

After the fall, Petitioner presented to Midwest Occupational Medicine and was referred to Memorial Hospital. He presented to the emergency room with complaints of headache, neck pain, right shoulder pain, right arm pain, radiating right leg pain and right hip pain. A variety of diagnostic studies were performed, including a chest x-ray, CT scan of the chest, and x-rays of the right shoulder, neck, and elbow. All diagnostic studies were negative. The radiologist commented that the x-ray of the right elbow showed a slightly impacted radial neck fracture, but he further noted that the film could be reflecting a ring of osteophytes. Petitioner's right hand x-ray suggested evidence of an old fracture, some possible arthritic changes, and a possible small avulsion injury. Petitioner did not await the results of the diagnostic films, as the records reflect that he left the facility prior to being discharged and prior to obtaining any results. (PX 1, 4)

Petitioner followed up with his primary care physician on July 16, 2010 reporting the injury and explaining that he had landed on his right side when he fell through the ceiling and bruised his right neck, shoulder, forearm, and hip. Petitioner complained of some right hip pain and some soreness in h is right neck, shoulder and forearm. The doctor noted he appeared well and had full range of motion of his shoulders, elbows, wrists, fingers, hips, knees and ankles with no significant swelling, redness or warmth. He was sent for a right hip x-ray that was negative. (PX 8)

Petitioner was again seen at Memorial Hospital on July 17, 2010 at which time he was given a splint and instructions. (PX 1)

In a note dated the 21st of July, Petitioner's doctor noted that Petitioner's right arm was in a sling and he had been diagnosed with a right radial head fracture, which did not require surgical intervention. His treatment remained conservative, including prescription medication, range of motion exercises, and remaining off of work. (PX 8)

According to his doctor's notes, Petitioner remained symptomatic in his right shoulder and arm and on July 27, 2010 Petitioner was prescribed physical therapy for his right arm and shoulder pain (three weeks, three times a week). (PX 8)

On July 29, 2010 a right elbow x-ray was taken revealing slight irregularity at the radial head and neck junction suspicious for an impacted fracture. An MRI was recommended. (PX 4)

On August 6, 2010, Petitioner presented to Dr. Steven Horner. He had complaints of injury to his right shoulder and right elbow and hip. Petitioner described the accident including mentioning that debris had fallen on top of him. Petitioner was off work at the time of the exam. The physical examination found Petitioner to have full range of motion in his right shoulder, but some complaints of pain and tenderness with movement. His rotator cuff strength was found to be intact. His right elbow was asymptomatic, with no tenderness or instability and full range of motion. Dr. Horner performed a new x-ray of Petitioner's right elbow, which was identical to the x-ray taken at Memorial Hospital. Dr. Horner saw no evidence of a fracture; only evidence of a small osteophyte ring at the radial neck. (PX 10)

Dr. Horner diagnosed Petitioner with a Grade I AC separation of the right shoulder, which was found to be resolving. He was also diagnosed as having a mild sprain/contusion to his right elbow. He was given an off-work slip for three (3) weeks. After three (3) weeks of rest, Dr. Horner opined that Petitioner "should be fine." He was also instructed to discontinue the use of the sling he was given at the emergency room. (PX 10)

Petitioner continued to complain of on-going right shoulder pain. An MRI was performed on September 8, 2010, which revealed AC degenerative disease, tiny bursal effusion, rotator cuff tendonopathy, and a partial insertional tear of the supraspinatus tendon. He was diagnosed with right shoulder impingement syndrome with a rotator cuff tear and ordered to undergo physical therapy three (3) times per week for four (4) weeks. (PX 6)

By letter dated September 13, 2010 Dr. Abel requested that Dr. Horner examine Petitioner's right shoulder for a "rotator cuff injury following a work-related accident." (PX 10)

Petitioner began physical therapy at Phoenix PT on September 20, 2010. (PX 13)

Petitioner cancelled his physical therapy appointment at Phoenix PT scheduled for September 21, 2010. (RX 7)

Petitioner failed to appear for his September 23, 2010 physical therapy appointment. (RX 7)

On September 23, 2010, Petitioner presented to Dr. Weimer, another physician in Dr. Horner's medical group. Dr. Weimer reviewed the right shoulder x-rays, which he felt revealed moderate joint arthritis. The review of the MRI revealed impingement at the AC joint, bursal surface tendinosis, and a partial-thickness articular-sided tear of the supraspinatus. It was Dr. Weimer's opinion that Petitioner needed a right shoulder arthroscopy with decompression, distal clavicle excision and debridement; a repair of the supraspinatus tear was not recommended. (PX 8, 10)

Petitioner failed to appear for his September 27, 2010 physical therapy appointment; however, a therapist noted Petitioner did so on the advice of his attorney who had told him to hold off until workers' compensation approved it. (RX 7)

On October 12, 2010, Petitioner underwent surgery on his right shoulder. Dr. Weimer's pre-operative diagnosis was right shoulder subacromial impingement, acromioclavicular joint osteoarthritis, and a partial rotator cuff tear. The post-operative diagnosis was right shoulder subacromial impingement, acromioclavicular joint osteoarthritis, bursal surface rotator cuff tendinosis and a Type I superior labrum anterior posterior lesion. Dr. Weimer performed a right shoulder arthroscopy with arthroscopic subacromial decompression, arthroscopic distal clavicle excision, debridement of bursal surface rotator cuff tendinosis and debridement of a Type I superior labrum anterior posterior lesion. (PX 11)

Petitioner failed to appear for physical therapy on October 20, 2010. (RX 7)

As of November 1, 2010 Petitioner was attending physical therapy but not fully completing his home exercise program. Petitioner reported soreness in his shoulder. (RX 7) Petitioner rescheduled his November 3, 2010 appointment and failed to appear on November 8, 2010. He was again noted to be having trouble with full compliance in his home exercise program on November 10, 2010 and he failed to appear on November 11, 2010 or December 1, 2010. (RX 7)

Petitioner attended physical therapy on December 10, 2010, and the physical therapy records reflect that Petitioner's "wife attempted to fight [him] and had to use his right arm in self-defense to block her." At his next visit on December 13, 2010, the therapist noted Petitioner told him he "was joking about fighting with his wife last appointment." The records reflect that he still had pain complaints and "continues to arrive late for appointments." (RX 7)

As of January 24, 2011 Petitioner was advising the therapist he was frustrated by his shoulder pain and not performing his home exercise program as frequently as he should. He either cancelled or failed to appear for therapy on January 28, 2011, January 31, 2011, February 2, 2011 and February 7, 2011. Petitioner failed to appear on February 15, 2011. (RX 7)

At six (6) weeks post-operation, Petitioner continued to have subjective complaints of loss of strength and pain, as well as decreased range of motion in his shoulder. Dr. Weimer diagnosed him with adhesive capsulitis. He provided him an injection and a slip for additional physical therapy. (PX 8; 10)

As of February 18, 2011 Phoenix Physical Therapy was noting ongoing struggles with right shoulder pain and certain movements -- elevation, horizontal adduction, and right side lying. (PX 10)

By February 21, 2011, four (4) months after surgery, Petitioner still continued to complain of pain in his right shoulder. A repeat MRI was performed on February 16, 2011 and showed supraspinatus tendinosis with partial articular surface tears, a focal full thickness tear along the anterior distal aspect of the supraspinatus tendon, a bone cyst at the right humeral neck and degenerative changes within the acromioclavicular joint. Based upon these MRI findings, Dr. Weimer recommended a repeat surgery. Petitioner wished to proceed pending approval by workers' compensation. (PX 8; 10)

Petitioner continued to attend most of his therapy appointments through early March of 2011.

In a letter dated March 4, 2011 to Dawn Lawrence at CCMSI, the therapist wrote that he had seen Petitioner the week before and that Petitioner advised him he had a 2 cm. tear in his right rotator cuff that wasn't there before and "reportedly placed the blame on physical therapy." The therapist spoke with Dr. Weimer who denied making such a comment to Petitioner. Dr. Weimer did not feel rehab was doing anything incorrectly and that Petitioner's tendon was weak and rehab or activities could cause a weak tendon to tear. The therapist noted multiple cancellations and no-show appointments. Physical therapy was being placed on hold. (RX 7)

As of March 8, 2011 no further therapy was ordered by Dr. Weimer pending approval. (PX 10)

On May 19, 2011, Dr. Michael Nogalski conducted a records review at the request of Respondent. Dr. Nogalski reviewed medical records from Phoenix Physical Therapy, Elite Imaging, Memorial Hospital, Belleville Orthopedic Surgeons, Dr. Horner, Dr. Prieb, Dr. Lal, and Elite Imaging. (RX 2, pp. 8-22, dep. ex. 2)

Following his review of all the medical records, Dr. Nogalski opined that Petitioner sustained a "contusion or strain to the right side of his body with some right upper extremity pain and shoulder problems." Given the findings in the "early part of this record" he would have recommended conservative treatment (injections and physical therapy); however, if that failed he would consider moving forward with surgical intervention. (RX 2, p. 23, dep. ex. 2) However, he did not feel that the medical records he had reviewed supported surgical intervention. (RX 2, p. 27)

Dr. Nogalski went on to state in his report that Petitioner's current condition in his shoulder was not related to his work-related accident, but rather the pre-existing AC joint arthritis in his shoulder. Dr. Nogalski referenced a letter of April 4, 2011 that he had reviewed as part of the examination process. He concluded that there would reasonably be support for a shoulder strain or contusion and that all "ongoing treatment" was reasonable and necessary with regard to the July 15, 2010 injury and Petitioner was at maximum medical improvement (MMI). It was "not clear at all" to Dr. Nogalski whether there was a specific problem with Petitioner's shoulder that would necessitate a second surgical intervention from a work-related stand point and, in any event, it didn't appear that any surgery would be related to the accident. (RX 2, dep. ex. 2, p. 4)

Dr. Nogalski went on to state that a shoulder contusion might or could have aggravated Petitioner's shoulder thereby necessitating diagnostic arthroscopy and potential treatment for issues at that time. However, he believed Petitioner's current condition was related to pre-existing conditions and not work activities. However, he also noted, "it could be related to surgical procedures." (RX 2, dep. ex. 2, p. 4) He did not feel rehab efforts for the shoulder would reasonably strain Petitioner's shoulder above and beyond normal physiologic levels. He found it "difficult to comment" upon whether or not lack of compliance in a physical therapy program would change Petitioner's course of action with respect to subjective complaints of rotator cuff tendinopathic issues. Dr. Nogalski went on to state, "In fact it is often the case that a shoulder surgery, even if done perfectly, could even create a worse problem if adequate rehab has not been performed by the patient." (RX 2, dep. ex. 2, p. 4)

While Dr. Nogalski felt Petitioner was at MMI, he felt Petitioner would require some type of functional capacity evaluation to clarify his ability to work especially in light of his work as a firefighter. At a minimum he felt Petitioner could lift, at least, 50 lbs. at chest level and anything above chest level would be speculative although he felt Petitioner was probably capable of some significant material handling capacities. Finally, he concluded Petitioner did sustain some permanent injury as a result of his accident and surgery. (RX 2, dep. ex. 2, p. 5)

On August 30, 2011, Petitioner underwent a second right shoulder arthroscopy with arthroscopic repair of an intra-substance insertional supraspinatus rotator cuff tear, debridement of bursal surface rotator cuff tendinosis, and an arthroscopic subacromial decompression. The pre-operative diagnosis was right shoulder rotator cuff tear. The post-operative diagnosis was right shoulder intra-substance supraspinatus insertional rotator cuff tear of less than 1 cm., bursal surface rotator cuff tendinosis and subacromial impingement. (PX 11)

Petitioner presented for a physical therapy evaluation on October 15, 2011. According to the history he provided, Petitioner had fallen through a second story and his right arm got caught on a window sill as he fell. He further explained that he had undergone surgery on October 12, 2010 but "re-tore" it in therapy probably around December of 2010. (PX 2)

Following another course of physical therapy in October, November, and December of 2011 (PX 2), Petitioner was released to return to work, full duty, without restrictions effective February 1, 2012. At the time of his final exam with Dr. Weimer, Petitioner was noted to have elevation of 170 degrees compared to 180 degrees on the left side, adduction to 40 degrees compared to 50 degrees, and abduction of 90 degrees compared to 95 degrees on the left. Strength was "+5." Jobe's was negative. (PX 11)

Dr. Weimer, a board certified orthopedic surgeon, was deposed on July 10, 2014. He primarily focuses his practice on shoulders. (PX 16, p. 27) Dr. Weimer was of the opinion that the surgical findings of October 12, 2010 could certainly be exacerbated by Petitioner's July 15, 2010 accident. (PX 16, p. 13) Dr. Weimer testified that Petitioner was taken off work as of September 23, 2010. (PX 16, p. 16) Post-operatively Petitioner underwent physical therapy and was given a cortisone injection as Dr. Weimer suspected Petitioner might be developing adhesive capsulitis (frozen shoulder). (PX 16, p. 15) Thereafter, Petitioner continued to improve but was not fully recovered and Dr. Weimer ordered a second MRI which showed an anterior supraspinatus tendon tear which had not been observable during the earlier surgery because the tear was within the tendon. (PX 16, pp. 18 - 21) According to Dr. Weimer, Petitioner's second surgery followed which showed progression of an intra-tendinous tear that required repair. (PX 16, pp. 20 - 21) Dr. Weimer felt the tear occurred at the time of Petitioner's accident but had progressed over time. (PX 16, pp. 21 - 23) Thereafter, Petitioner's recovery was uneventful and Petitioner was released on January 30, 2012 with no restrictions and near normal range of motion and strength and no evidence of any rotator cuff pain. (PX 16, p. 24)

On cross-examination Dr. Weimer was asked about details of Petitioner's accident such as whether Petitioner had told him exactly how it occurred or if he struck his right shoulder when falling. Dr. Weimer did not know. Dr. Weimer was further asked about physical therapy records and his knowledge of any attendance issues to which the doctor appeared unaware. (PX 16, pp. 31 -32) Even assuming Petitioner had missed some appointments Dr. Weimer felt it may have had no impact or it may have contributed to the frozen shoulder issue but he could not give an opinion on it. (PX 16, p. 33) Dr. Weimer was also asked about his operative findings. He acknowledged that that the conditions for which he recommended and performed surgery could all be degenerative in nature and result from normal "wear and tear" of one's shoulder. Finally, he acknowledged that

his opinion on causal connection could be impacted by evidence of right shoulder complaints five days before Petitioner's July 15, 2010 accident. (PX 16, p. 42)

Respondent's examining physician, Dr. Nogalski, was deposed on August 18, 2014. According to Dr. Nogalski, an orthopedic surgeon, Petitioner sustained a contusion or strain to the right side of his body with some right upper extremity pain and shoulder problems. There was no clear objective documentation of injury to his right shoulder. By history, a direct blow injury might create an AC joint strain or irritation, but there was no soft tissue swelling or bone marrow signal change in the MRI. The recommended course of treatment would include conservative treatment of injections and physical therapy to determine if soft tissue symptoms could have improved. (RX 2)

Dr. Nogalski testified that prior to the July 15th accident Petitioner had AC joint degenerative changes, as well as tendinosis or tendonopathy in the rotator cuff. He may or may not have had some labral abnormalities in the shoulder, but type I superior labral abnormality can be an incidental finding on many patients' arthroscopies as they get older. Dr. Nogalski further testified that symptoms of tendinosis and type I AC conditions can generate pain with reaching or holding objects away from the body, pain if you lay directly on the shoulder, pain with forward flexion and abduction, and possibly some mechanical abnormalities including catching or pain in front of the shoulder. (RX 2)

At the arbitration hearing Petitioner testified that from February 1, 2012 through the time of hearing, he has worked full-duty with no restrictions as fire fighter for Respondent. His job requires him to operate and drive the firetruck and provide water and equipment to his fellow firefighters. He has not had any ongoing medical care and treatment, nor has he missed any time from work as it related to his right shoulder. Petitioner testified that he returned to work when his chief told him to. Petitioner requested and received a release to return to work from his treating physician at that time.

Petitioner testified that he didn't always attend physical therapy as scheduled because he, as a single parent, had other things to take care of, such as his teenage children and getting them to and from school and related activities.

Petitioner further testified that while he can perform his job as a lieutenant/engineer for Respondent he cannot lift as much weight as he could prior to July 15, 2010, nor can he steer the fire truck in the same manner as he could prior to the accident. Specifically, Petitioner cannot carry as many sets of the "Jaws of Life" (one set at a time as opposed to more than one set) as he could prior to the accident, and other job-related activities require "more effort" than they did prior to July 15, 2010. Petitioner only drives with one arm/hand.

Petitioner testified that after he began to lose time from work he received his regular salary for approximately one year.

Petitioner also testified that since being released to return to work on December 1, 2012 he has "applied' for additional treatment with Dr. Abel; however, he has been told to take up any issues with Dr. Weimer. Rather than do so, Petitioner has just "worked through it."

Petitioner also acknowledged having a problem with his shoulder about eight days before his accident. He described muscle cramps across his back and right arm, the latter of which he could barely move. Petitioner testified that Dr. Abel changed his high cholesterol medicine.

Petitioner also testified that the reported incident with his wife in the physical therapy records was just a joke.

Petitioner's supervisor, Chief Jason Blackmon, testified that since returning to work in February of 2012, Petitioner has been able to perform all pertinent aspects of his job as a lieutenant, including driving the truck, transferring water, loading and unloading the truck, assisting firefighters with equipment, and wear all required pieces of firefighting gear, including pans, jacket, helmet, hood, boots, and the SCBA, which is a breathing apparatus that weights 15-20 pounds.

Ms. Monica Grandberry testified on behalf of Respondent and authenticated Respondent's Exhibit 5, Petitioner's attendance records from 2010-2012. Petitioner, on cross-examination, indicated that he had been paid his regular salary for fifty-two (52) weeks as a "PEDA" benefit, presumably paid to firefighters injured on the job.

The Arbitrator concludes:

Issue F: Causal Connection:

Petitioner's current condition of ill-being in his right elbow and right shoulder is causally connected to his accident of July 15, 2010. The Arbitrator bases her conclusion on a chain of events and the opinions of Dr. Abel and Dr. Weimer, the latter of whose opinions are deemed more persuasive in this instance than that of Dr. Nogalski.

Petitioner sustained an undisputed accident on July 15, 2010. The evidence in the record indicates Petitioner was fighting a fire when the structure collapsed causing Petitioner to fall approximately 8 to 10 feet from one floor to another. While falling Petitioner's right arm hit a window sill and when he landed on the floor debris was falling on him. This evidence was unrebutted.

Petitioner sought medical treatment for injuries to his right arm, shoulder, and hip as well as his head, and neck. Based upon the record herein, Petitioner's injuries to his head, neck, and right hip resolved within a reasonable period of time after the accident.

There appears to be some dispute as to whether Petitioner sustained a fracture in the right elbow area (radial head) as was documented in treatment records generated on or about Petitioner's accident date or a contusion. The MRI recommended by the radiologist reading the right elbow x-ray on July 29, 2010 was never performed. Petitioner was examined by Dr. Horner shortly thereafter who believed Petitioner had a small osteophyte ring at the radial neck rather than a fracture and concluded Petitioner had sustained a right elbow strain/sprain. Petitioner's injury to his right elbow is causally connected to the accident of July 15, 2010.

While Petitioner did see his family physician for complaints of right shoulder symptoms on July 7, 2010, he only complained of mild discomfort in the shoulder for which he had not taken any medication or lost any time from work. Petitioner testified that Dr. Abel changed his cholesterol medications as a result of his complaints. Dr. Abel's records do indicate that Petitioner had been prescribed cholesterol medication prior to this visit although nothing is stated about a medication change in the July 7th note. While Petitioner's explanation isn't entirely corroborated by the doctor's notes, there is sufficient difference in the nature of the complaints on the 7th and after Petitioner's accident that those differences, combined with Petitioner's ability to work full duty up to the time of the accident, diminish the significance of the July 7th visit. Respondent could

have deposed Dr. Abel regarding these complaints if it so chose. It did not. The Arbitrator further notes that, other than that one isolated visit on July 7, 2010, the record is devoid of prior right shoulder or elbow problems. The Arbitrator has also considered this prior visit in a light most favorable to Respondent and weighed it against the fact that Petitioner continued to work full duty thereafter and was physically involved in battling a fire when he fell through a floor and fell eight to ten feet, hitting his right arm on a window sill and having debris fall on top of him. The mechanism of injury was significant.

Prior to seeing Dr. Horner, Petitioner's right arm was in a sling thereby reducing Petitioner's ability to use his right arm and shoulder. Both Dr. Abel and Dr. Horner noted upper extremity injuries post fall. Dr. Horner initially believed Petitioner had sustained a Grade I AC right shoulder separation and Petitioner was told to stop wearing his right arm sling. Thereafter, Petitioner's right shoulder complaints progressed and Dr. Abel, believing that Petitioner had sustained a work-related rotator cuff tear (PX 10), referred Petitioner back to Dr. Horner. Petitioner was, however, seen by Dr. Weimer, Dr. Horner's partner and shoulder specialist. Dr. Weimer credibly and persuasively connected up Petitioner's two surgeries with his accident. Additionally, the Arbitrator notes that Dr. Nogalski did not dispute causation between the accident and Petitioner's first surgery and, furthermore, acknowledged a possible connection between Petitioner's need for the second surgery and the fact he had undergone a first surgery (which was necessitated by the accident). The Arbitrator also notes that Dr. Nogalski never examined Petitioner. Had he done so, he might have gotten a more detailed description of the accident, including the fact Petitioner hit his right arm while falling and had debris falling on him. That might have provided Dr. Nogalski with the clear objective documentation of an injury to Petitioner's right shoulder which, initially, he felt was missing. Generally speaking, Dr. Nogalski-made enough concessions in his report and during his deposition to lessen the persuasiveness of his opinions.

The Arbitrator has also considered Respondent's contentions regarding the role of non-compliance and attendance problems relating to Petitioner's therapy, the circumstances surrounding the one therapy visit in which he "jokingly" remarked about a domestic altercation, and Petitioner's ongoing belief (as stated in some of the records) that he had sustained a fractured elbow and re-injured his right shoulder during physical therapy. While Petitioner's credibility is called into light by his choice of topics to joke about, his demeanor, hesitancy, and voice when trying to explain why he didn't always attend physical therapy appointments or the circumstances surrounding his July 7, 2010 visit with his doctor, it is not enough to deny causation in light of an undisputed accident herein. In light of the totality of the circumstances and the opinions of Drs. Abel and Weimer Petitioner met his burden of proof. With regard to Petitioner's belief that he fractured his elbow and injured his shoulder in rehab, the Arbitrator views Petitioner's interpretation of his conditions as a layperson's beliefs and nothing more. His interpretations may not have been entirely correct once all the records were reviewed but they weren't completely wrong either -- just a misinterpretation.

Issue L: Nature and Extent of Petitioner's injury:

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 80.06 weeks, because the injuries sustained caused the 2% loss of use of the right arm for the right elbow injury and 15 % Man as a Whole for the right shoulder injury. Petitioner failed to prove he sustained any permanent partial injury to his right hip, head, or neck as a result of his accident.

With regard to Petitioner's right elbow, Dr. Abel and Dr. Horner repeatedly diagnosed Petitioner as suffering from a mild sprain/contusion to his right elbow, as reflected numerous times in the medical records. A fracture was never really confirmed. By August 6, 2010, Petitioner reported that his right elbow was asymptomatic, with no tenderness or instability, and that he had full range of motion.

With regard to Petitioner's right shoulder, Petitioner has undergone two surgeries, physical therapy, and has been released to return to full duty work. He has returned to his regular job for Respondent and his testimony concerning the changes in the manner in which he performs his job duties was credible and unrebutted. Petitioner is 52 years old.

Issue J, Whether all medical services provided to Petitioner were reasonable and necessary?

Petitioner's treating surgeon, Dr. Weimer, testified that all the services he provided and/or ordered or prescribed were reasonable, necessary services to help relieve the effects of what the Arbitrator has determined were work-related injuries (PX. 16 pp.10, 11, 12, 13, 15, 22, 23, 24, 26). That testimony was not refuted. Respondent's medical records examiner, in his May 19, 2011 letter to Respondent's counsel indicated that evaluation and treatment up to that time appeared to be reasonable and necessary (RX 2, dep. ex. 2). Dr. Nogalski did not specifically address the reasonableness or necessity of any treatment provided to Petitioner after May 19, 2011 (RX 2)

PX 3 contains bills from Memorial Hospital with outstanding balances set forth and amount paid by group.

PX 5 contains bills from St. Elizabeth's for services rendered. Services rendered on 7/16/10, 7/27/10, and 7/29/10 have been paid. Page 5 reflects an outstanding bill of $3303.89 and Respondent is liable for it.

PX 9 contains bills from Belleville Family Medical Group. Respondent is only liable for services rendered between July 16, 2010 and October 11, 2010 (pre-surgery visit). It appears all of these visits have been paid except for the October 11, 2010 office visit.

PX 12 contains bills from Belleville Orthopedic. All have been paid and the balances are zero.

PX 14 contains the bills from Phoenix Physical Therapy. Those have been paid and the balance is zero.

Respondent is liable for the bills contained in PX 3, 5, 9, 12, and 14; however, Respondent is not liable for any services reflected in PX 9 occurring after October 11, 2010. The Arbitrator acknowledges that Respondent has paid some bills as reflected in RX 4 and should receive credit for those payments. Respondent should also receive credit for any payments made pursuant to Petitioner's group medical plan as stipulated to between the parties and shall hold Petitioner harmless from same.

Issue K: What amounts are due and owing, if any, for Temporary Total Disability (TTD) benefits?

Petitioner, by his testimony, was off work pursuant to his treating physician's orders from September 23, 2010 through January 30, 2012, a period of 70 4/7 weeks. Ms. Monica Grandberry testified on behalf of Respondent and authenticated Respondent's Exhibit 5, Petitioner's attendance records from 2010-2012. Petitioner, on cross-examination, indicated that he had been paid his regular salary for fifty-two (52) weeks as a "PEDA" benefit, presumably paid to firefighters injured on the job. The remaining 18 4/7 weeks seem to be at issue. Respondent's Exhibit 5 indicates that Petitioner was, for the final 27 weeks of his off-work time, required to use sick time and vacation time in order to be paid for his time away from work (Respondent's Exhibit 5).

Petitioner testified that he returned to work when his chief told him to. Petitioner requested and received a release to return to work from his treating physician at that time.

The Arbitrator concludes that Petitioner was required to stay off work due to his work-related injuries for the time claimed (September 23, 2010-January 30, 2012), but that Petitioner has been paid his full pay for that time by operation of various benefit plans. Petitioner should have received a total of 70 4/7 weeks of TTD benefits.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Chanel Pease,

Petitioner,

15IWCC0610

vs.

NO: 12 WC 17860

Nightwood Restaurant,

Respondent.

DECISION AND OPINION PURSUANT TO §8(A), §19(K), §19(L) AND §16 OF THE ACT

This claim comes before the Commission on Petitioner's petition for review under §8(a), §19(k), §19(l) and §16 of the Act. Timely petition having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of liability for a NovaCare bill in the amount of $5,879.54 and penalties and fees and being advised of the facts and law, denies the petition for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner, a 34-years-old restaurant server on the date of accident, filed an Application for Adjustment of Claim alleging injuries related to an assault by a restaurant patron on October 10, 2009. This case was arbitrated on August 8, 2012. In a Decision dated February 28, 2013, the arbitrator awarded 2.5% loss of use of the person as a whole and payment of outstanding medical bills for treatment by Robert V. Olsen, D.C. ($966.64) and NovaCare ($5,879.54). However, the Arbitrator noted that the records of NovaCare in Petitioner's Exhibit #3 reflect "Total Account Adjustments of -6215.00 and an Account Balance due of 0.00." Therefore, the Arbitrator addressed the unknown status of the bill in the award. The Arbitrator wrote that if NovaCare had in fact written-off the bill, Respondent would not be liable.

Petitioner presented its petition under §8(a), §19(k), §19(l) and §16 of the Act before Commissioner White on February 5, 2015. Petitioner alleged that Respondent failed to pay the

15IWCC0610

NovaCare bill in the amount of $5,879.54 in accordance with the Arbitrator's decision and sought payment of the bill and penalties and fees for Respondent's alleged nonpayment. Petitioner alleged that NovaCare remitted the unpaid bill to National Recovery Services for collection. Petitioner testified that she believed National Recovery Services contacted Petitioner's attorney attempting to collect payment.

Respondent argued that penalties and fees are not warranted where Petitioner failed to prove the NovaCare bill remained outstanding and was not written-off and furthermore where Petitioner has refused to provide a signed authorization that would allow Respondent to investigate the status of the bill and pay any verified charges. The record shows that the last documented attempt at collection from National Recovery Services occurred approximately four months prior to the review hearing. We find no basis to award penalties and fees. Under §8(a) of the Act, undisputed bills shall be paid by the employer to the provider on behalf of the employee. In order for the bills to be satisfied, Petitioner must provide current authorization on written request. Petitioner testified that she would sign the requested authorization upon the recommendation of her attorney. As ordered by Arbitrator, Respondent shall pay any verified outstanding balance to the provider pursuant to the fee schedule.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §8(a), §19(k), §19(l) and §16 of the Act is hereby denied for the reasons set forth above.

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

DATED: AUG 1 0 2015
RWW/plv
o-6/9/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Miglio,

Petitioner,

15IWCC0611

vs.

NO: 07 WC 51755

United Parcel Service,

Respondent.

DECISION AND OPINION PURSUANT TO §8(A) OF THE ACT

This claim comes before the Commission on Petitioner's petition for review under §8(a). On January 16, 2015, the parties appeared before the Worker's Compensation Commission for a hearing in this matter. The issue on review is whether Petitioner is entitled to medical treatment in the form of bilateral knee injections of hyaluronan and prospective knee replacements as reasonable, necessary and related medical treatment causally connected to Petitioner's December 2, 2004 accidental injury. After considering all of the evidence and being advised of the facts and law, the Commission denies Petitioner's petition for review under §8(a).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner sustained accidental injuries arising out of and in the course of his employment by Respondent on December 2, 2004. Petitioner worked for Respondent as a delivery driver for approximately 25 years until he retired in May of 2007. On the date of accident, Petitioner stepped into a hole and injured both knees. Petitioner underwent a partial lateral meniscectomy by Dr. Robert Mitchell on January 31, 2005 on the right and on February 15, 2005 on the left. Petitioner returned to regular full duty work on April 21, 2005.

Petitioner alleged a second work-related injury to his right knee occurring on August 29, 2005. This second claim was ultimately barred by the statute of limitations as Petitioner failed to file an Application for Adjustment of Claim. Dr. Mitchell performed a second right knee arthroscopic surgery on January 23, 2006, and released Petitioner to full duty work in 2007.

Petitioner subsequently retired. While shopping on October 9, 2008, Petitioner experienced a spontaneous onset of right knee pain while shopping, allegedly due to the "explosion" of a baker's cyst; this was followed by recurrent cyst formation. Petitioner subsequently underwent a third right knee arthroscopic surgery by Dr. Mitchell on November 5, 2008.

Following the October 28, 2010 arbitration, the Arbitrator found that Petitioner was entitled to compensation for the permanent loss of use of 18% of each leg; the Arbitrator made no award for prospective medical care. The Commission, the Circuit Court, and the Appellate Court affirmed the Arbitrator's findings in this case. The Appellate Court agreed with the Commission that the August 2005 accident did not constitute a mere aggravation of the preexisting work injury. Rather, the medical evidence established a wholly separate accident resulting in new injuries. The Appellate Court was not persuaded that Petitioner should have been allowed to amend his Application under the "relation back doctrine" (§2-616 of the Code of Civil Procedure) that applies where the amended pleading grew out of the "same transaction or occurrence set up in the original pleading" and agreed with the Commission's denial of Petitioner's request to add a completely new cause of action outside of the statute of limitations to his existing Application for Adjustment of Claim. The Commission found that this was beyond the "amending" of pleadings allowed by §7020.20(e) of the Rules Governing Practice Before the Illinois Workers' Compensation Commission.

According to Petitioner's §8(a) petition, he now seeks further treatment for both knees in the form of right knee injections and prospective knee replacements. Petitioner testified that by January of 2014 he began experiencing increased pain. He testified that he had a right knee Cortisone shot followed by a series of Synvisc or Orthovisc injections to the right knee. Petitioner testified that the treatment helped, but that he was in need of repeated injections. We note that no corresponding medical records were offered into evidence to support Petitioner's testimony with respect to the treatment he received for the right knee in 2014. Dr. Mitchell issued a narrative letter dated May 27, 2014 wherein he reiterated: *"Once again I believe beyond a reasonable degree of medical certainty that this was related to his work related injury. He has currently been undergoing Orthovisc treatment, which I believe beyond a reasonable degree of medical certainty is needed to care for the patient's postoperative condition since he is developing some posttraumatic degenerative changes throughout his knees. I believe that his treatment is reasonable and necessary to assist the patient to get relief from his pain and allow him to live a normal life. I am not aware of any recent traumatic events form his original injury. I also believe that he will need to be monitored on a regular basis. He may need to undergo further treatment options, such as corticosteroid injections, further Orthovisc injections and even the possibility of total knee arthroplasty in the future."*

After considering all of the evidence and the law, we find that "intervening accident" is the law of the case, and Petitioner's current request for §8(a) benefits for the right knee shall not be granted. We note that in the nine years following Petitioner's April 21, 2005 release to full duty work, Petitioner sustained two non-compensable right knee injuries and underwent two surgeries. Dr. Mitchell's initial two narrative reports were included in the Commission's prior record, and there is nothing new in the third report dated May 27, 2014 that was submitted on review an unaccompanied by any medical records. Therefore, all of the opinions of Dr. Mitchell with respect to causal connection and prospective treatment were previously before the

15IWCC0610

Commission, and Petitioner was not found to be entitled to prospective medical treatment as a result of the December 2, 2004 accident.

We note that regarding Petitioner's left knee, there is no evidence that left knee treatment has been prescribed. Petitioner's §8(a) petition and brief *alleges* that left knee injections or potentially a total knee replacement would be related to posttraumatic degenerative changes stemming from the December 2, 2004 accident and Petitioner relies on Dr. Mitchell's May 27, 2014 letter in support of that claim. However, Dr. Mitchell's letter lacks specificity and he uses the singular "knee." As previously stated, there are no post-arbitration medical records in evidence.

On November 24, 2014, Dr. Ryon Hennessy performed a "chart review" at the request of Respondent. Dr. Hennessy also noted that while the course of Orthovisc treatment was mentioned in Dr. Mitchell's May 27, 2014 letter, he did not have actual records of the treatment to review. Dr. Hennessy disagreed with Dr. Mitchell's opinion that Petitioner may need a total knee arthroplasty as a result of acceleration of Petitioner's work-related condition. Dr. Hennessy noted that Petitioner appeared to have symptom relief by March of 2005 and when Petitioner returned to Dr. Mitchell in July and August of 2005 he had a new complaint of right *patellofemoral* pain, but no medial or lateral joint line tenderness, and therefore "his symptoms had changed when he claimed a new injury on 8/29/05 in which he slipped on oil." Dr. Hennessy opined that the condition caused by the original accident resolved and Petitioner was at maximum medical improvement prior to the second alleged accident on April 21, 2005 (by 4/21/05); although Petitioner began having patellofemoral pain, this was a new complaint. Dr. Hennessy opined that the two subsequent injuries were "greater" based on the hematomas present as well as the medial and lateral findings and that any additional medical treatment would be the result of the two subsequent accidents.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §8(a) is hereby denied for the reasons set forth above and no benefits are awarded.

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

DATED: AUG 10 2015
RWW/plv
o-6/10/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Stacy Ash,

Petitioner,

15IWCC0612

vs.

NO: 03 WC 43923
03 WC 49089

Bloomington Public Schools,

Respondent.

DECISION AND OPINION PURSUANT TO §8(A) OF THE ACT

This claim comes before the Commission on Petitioner's petition for review under §8(a). Commissioner White conducted a hearing in this matter on February 11, 2015. The issue on review is whether pain management treatment by Dr. Benyamin in the form of a spinal cord stimulator trial and adhesiolysis is reasonable and necessary and causally related to Petitioner's April 21, 2003 accidental injury. After considering all of the evidence and being advised of the facts and law, the Commission grants Petitioner's petition for review under §8(a) but only with respect to the spinal cord stimulator trial recommended by Dr. Benyamin.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In companion decisions dated January 2, 2007, the Arbitrator found that Petitioner was in the course of her regular employment as a cafeteria worker at Bloomington Public Schools on February 25, 2003. On that date she sustained an accident arising out of her employment by Respondent when she pulled her back lifting a case of juice. She initially sought treatment with her primary care provider and was able to return to her regular duties. The Arbitrator found that Petitioner did not sustain any permanent injury as a result of the February 25, 2003 accident. Subsequently, on April 21, 2003 Petitioner sustained another back injury when she lifted a box of canned goods. She returned to her primary care provider for treatment and was eventually referred to Dr. Nardone. Ultimately, Dr. Nardone performed a right L3-4 laminotomy and foraminotomy with disc exploration and a right L4-5 laminotomy and foraminotomy with disc exploration on November 3, 2003. Petitioner underwent post-operative physical therapy and was

able to return to work in December of 2006 with a permanent lifting restriction of forty pounds. At arbitration on December 19, 2006, Petitioner testified that she continued to experience back pain and leg pain with prolonged sitting and standing. She testified that she takes Tylenol and sleeps in a recliner at night to ease the pain. The Arbitrator awarded 25% loss of use of the person as a whole.

The month following arbitration, Petitioner began treatment at Millennium Pain Center for her ongoing complaints. Petitioner was examined by Dr. Atiq Rehman on January 24, 2007. By this time, Petitioner no longer worked for Respondent and indicated that she was employed as a medical technician for BroMenn Hospital. She complained of left-sided low back and buttock pain with an average pain level of 5-6/10. Dr. Rehman diagnosed facet joint arthropathy, degenerative disc disease and failed back surgery syndrome. Dr. Rehman recommended facet joint injections and the medication Nortriptyline. Petitioner underwent bilateral lumbar facet medial branch blocks at L2-3, L3-4, L4-5, L5-S1 on January 25, 2007 and a right SI joint injection on February 5, 2007. An August 27, 2007 lumbar MRI indicated postsurgical changes on the left side at the L3-4 level without a recurrent disc herniation and a mild degree of postsurgical scarring. The scan also showed evidence of varying degrees of spinal stenosis at the L2-3, L3-4, L4-5, and L5-S1 levels, a focal right paracentral disc herniation at L5-S1 and a small central disc herniation at L4-5. On August 30, 2007, Dr. Rehman administered a bilateral L4-5 transforaminal epidural steroid injection and SI injections. Petitioner returned to Dr. Rehman on May 29, 2008 and reported that the pain had returned over the prior six months. Dr. Rehman repeated the bilateral L4-5 transforaminal epidural steroid injections and SI injections. Dr. Rehman once again administered bilateral L4-5 injections on December 22, 2008. Petitioner followed up with Dr. Rehman on July 30, 2009 and reported some improvement as a result of the injections and use of the medication Lyrica.

On March 23, 2010, Dr. Van Fleet examined Petitioner at the request of Respondent. Dr. Van Fleet was not provided with enough information to issue a diagnosis and recommendations and he requested copies of imaging studies to review.

After Dr. Rehman left Millennium Pain Center, Petitioner began seeing Dr. Ramsin Benyamin on July 19, 2010. Petitioner complained of low back pain that was most severe on the left side and radiated to her left foot. Dr. Benyamin recommended a new MRI and the medication Vicodin to be taken as needed for pain. An August 27, 2010 MRI showed postsurgical changes at L3-L4 level with the suggestion of small focal central and right paracentral recurrent disc herniation and mild to moderate central and lateral recess stenosis. Mild stenosis was also seen at L4-L5 and L5-S1 levels. On April 26, 2011, Dr. Benyamin administered left L3-4 transforaminal epidural steroid injections. He noted that if Petitioner failed to have any significant relief he would recommend adhesiolysis. On January 12, 2011, Dr. Benyamin concluded that Petitioner had failed conservative treatment because she was still complaining of the same symptoms of low back pain radiating down the left leg. Therefore, Dr. Benyamin recommended a trial of a spinal cord stimulator.

On May 18, 2012, Dr. Van Fleet reexamined Petitioner. Dr. VanFleet was provided with medical records and imaging reports, but no films. He opined that he would not recommend percutaneous adhesiolysis because he did not believe that the procedure had been proven to

produce good outcomes. He testified that he has not personally seen an adhesiolysis procedure of the type recommended by Dr. Benyamin performed. Further, Dr. VanFleet believed that Petitioner's current symptoms were actually related to her multilevel degenerative disc disease, not post-surgical scar tissue. *"In any event, this is not related, in my opinion, to a 2003 work-related injury, and is related to an underlying progression that is seen naturally in the lumbar spine consisting of the natural progression and nature history of lumbar DDD."*

Dr. Van Fleet was deposed on September 19, 2012. Dr. VanFleet testified that he is a board-certified practicing orthopedic surgeon who regularly performs spinal surgery. He explained the theory of adhesiolysis is that scar tissue is irritating the nerve root; the procedure is therefore intended to release the nerve from the scar tissue. Dr. VanFleet testified that he did not believe scar tissue was causing Petitioner's left-sided buttock and left leg pain. Although everyone develops some scar tissue as a result of surgery, he testified that scar tissue is not usually a source of pain. Dr. VanFleet believed that the injections Petitioner received were reasonable and necessary treatment for her spinal stenosis, and were more likely to be effective than adhesiolysis. He testified that if epidural steroid injections were successful, there would be no harm in repeating them every six months. Dr. VanFleet denied that the 2003 surgery contributed to the stenosis he believes is causing Petitioner's pain. Dr. VanFleet explained that laminotomies are actually the treatment for spinal stenosis - opening up the spinal canal. Dr. VanFleet testified that Petitioner's current stenosis was new and not related to the accident or the 2003 surgery. Dr. VanFleet did not believe that a disc herniation could develop as a result of having back surgery, and he testified that scar tissue cannot accelerate or cause a disc herniation. He believed that Petitioner's pain was most likely the result of spinal stenosis; he agreed that it was possible that it was also related to disc herniations.

Petitioner returned to Dr. Benyamin on March 25, 2013. Dr. Benyamin noted that Petitioner complained of low back pain with left leg pain radiating to the little toe. Dr. Benyamin had not yet received a copy of Petitioner's IME report. Dr. Benyamin recommended a new MRI due to Petitioner's new clinical findings at the left S1 distribution causing reduced sensation and S1 reflexes. Dr. Benyamin was deposed on June 26, 2013. Dr. Benyamin is a board certified anesthesiologist who practices pain management treatment. Whereas the focus of Dr. VanFleet's deposition was with respect to the adhesiolysis procedure, Dr. Benyamin was largely questioned with respect to the reasonableness and necessity of a trial spinal cord stimulator. He testified that he recommended a trial spinal cord stimulator because no other treatment relieved the symptoms of Petitioner's post-laminectomy syndrome. Dr. Benyamin explained that spinal cord stimulators have been shown in cases of post-laminectomy syndrome to basically mask the pain in the back and legs. Dr. Benyamin testified that there are many reasons for post-laminectomy or failed back surgery syndrome, including the presence of scar tissue. In addition to the stimulator trial, Dr. Benyamin also recommended adhesiolysis, wherein you access the epidural space and inject an enzyme that dissolves scar tissue and a steroid and medication to shrink inflammation compressing the nerve. Dr. Benyamin testified that the last time he saw Petitioner, on March 25, 2013, she had new symptoms. The left leg pain was *"more to the lateral part of the leg and going towards the little toes. Very typical of S1 nerve distribution. And she had – ironically, she had less sensation in that distribution. And more importantly was her ankle reflex on the left side which is controlled by the S1 nerve was diminished."* Due to indications of new pathology affecting the left S1 nerve he wanted to get a new MRI. Dr. Benyamin also noted that Petitioner

had positive straight leg raise test which is a sign of tension on the nerve root. Dr. Benyamin testified that at this point he could not recommend any treatment without new images, and that he is concerned that long time compression of the nerves will cause permanent nerve damage. Dr. Benyamin was asked whether he could testify within a reasonable degree of medical certainty that the current need for the MRI is related to the November 2003 surgery. He answered: *"It's hard to say without, you know, having the MRI. But the symptoms are at a different level, at least clinically. So, I don't think it's related to that," and "I don't think it would be related, but you never know. I have been surprised before."* He thought that possibly instead there is a *new* disc herniation at L5-S1.

Dr. Benyamin was asked whether he could testify that within a reasonable degree of medical certainty the treatment he has been providing has been related to the November 2003 back surgery. He answered *"I don't have any reason to believe otherwise."* He was asked whether Petitioner's back pain was related to the surgery and he answered *"Most probably."* He testified that the incidence of patients with failed back syndrome following hemilaminectomy is between 25-35%. He opined that the disc herniation at L3-4 on the left that was seen in the 2010 MRI occurred after November of 2003; he opined that the surgery could have triggered scar tissue and instability. Dr. Benyamin was also asked if the new symptoms could be from the natural progression of degeneration. He answered *"Could be. I mean, we don't know."* He added that it was too speculative to say what exactly caused or contributed to it Petitioner's current condition.

On October 11, 2013 Petitioner had a new MRI. The scan showed a relatively stable lumbar spine since August 27, 2010, with degenerative disc disease and small disc herniations at the lower four segments. The disc herniation at L5-S1 level appeared to have progressed slightly in the interim and was encroaching upon he lateral recesses and S1 nerve root sleeve. Dr. Benyamin issued a causation letter dated December 2, 2013 in support of his recommendations. Dr. Benyamin wrote that in three years the degenerative process at L5-S1 had not progressed and the disc heights had essentially stayed the same. Dr. Benyamin believed that Petitioner had annular tears and disc protrusions combined with facet disease at multiple levels. He testified that reasonable treatment options, considering Petitioner had no success with prior surgery, were adhesiolysis combined with physical therapy, or a spinal cord stimulator.

After consideration of the facts and the evidence in this case, the Commission grants Petitioner's petition under §8(a) with respect to the trial spinal cord stimulator. Dr. Benyamin testified that the trial allows the patient to see if the device will work before implanting the stimulator under the skin. A spinal cord stimulator operates to mask pain and is used when other treatment has failed. We rely on the opinion of Dr. Benyamin with respect to the reasonableness and medical necessity of this procedure. Dr. Benyamin is a board certified anesthesiologist and pain management specialist. Dr. VanFleet did not testify that a spinal cord stimulator trial would be an unreasonable or unnecessary course of treatment for failed back surgery syndrome. It appears that Petitioner continues to experience pain and discomfort as a result of the November 3, 2003 laminectomy, although she has developed new symptoms that were not proven to be related to the accident and 2003 surgery. We find that Petitioner is entitled to additional medical treatment in the form of a trial spinal cord stimulator and the medical expenses related thereto and those incurred to date that are related to Petitioner's work-related condition.

15IWCC0612

Petitioner offered the records of Millennium Pain Center as its Exhibit #2. The correlating bills were included in Petitioner's group bills Exhibit #5. We find that Petitioner is entitled to payment of the medical bills from Millennium Pain Center and bills from OSF Medical Group, St. Joseph Medical Center, Diagnostic Neuro Technologies and Bloomington Radiology for treatment and testing ordered by Millennium Pain Center.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's petition under §8(a) is hereby granted as stated above and only with respect to the trial spinal cord stimulator. Respondent shall authorize and pay for the trial spinal cord stimulator placement recommended by Dr. Benyamin and shall pay any outstanding medical expenses associated with Petitioner's work-related low back condition and reflected in Petitioner's Exhibit #5. Respondent shall hold Petitioner harmless for any demands for reimbursement by group insurance on amounts paid on her behalf and related amounts paid by the Illinois Department of Public Aid.

Bond for removal of this cause to the circuit Court by Respondent is hereby fixed at the sum of $15,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 10 2015
RWW/plv
o-6/9/15
46

Ruth W. White

Joshua D. Luskin

Charles J. DeVriendt

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Donald Keller,

Petitioner,

vs.

NO: 12 WC 40626

15IWCC0613

State of Illinois/CMS,

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, medical expenses, temporary total disability, permanent partial disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

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

DATED: AUG 10 2015
TJT:yl
o 7/21/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KELLER, DONALD
Employee/Petitioner

Case# **12WC040626**

STATE OF ILLINOIS
Employer/Respondent

15IWCC0613

On 1/6/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 6M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
FARRAH L HAGAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62703-2487

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

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

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

JAN 6 - 2015

RONALD R. HARDIA, Acting Secretary
Illinois Workers' Compensation Commission

15IWCC0613

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Donald Keller
Employee/Petitioner

v.

State of Illinois
Employer/Respondent

Case # **12** WC **40626**

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 **Herrin**, on **October 9, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **June 18, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**54,683.00**; the average weekly wage was $**1,051.60**.

On the date of accident, Petitioner was **65** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of $**any benefits paid through group** 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 §8(a) of the Act. Respondent shall have credit for any amounts paid through its group carrier, but shall indemnify and hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in §8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $701.07/week for 14 weeks, commencing November 27, 2012 through March 4, 2013, as provided in §8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $630.96/week for 63.25 weeks, because the injuries sustained caused the 12.65% loss of the person as a whole, as provided in §8(d)2 of the Act.

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

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

Signature of Arbitrator

12/19/14
Date

JAN 6 - 2015

15IWCC0613

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

DONALD KELLER
Employee/Petitioner

v. Case # 12 WC 40626

STATE OF IL/CMS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On the date of the accident, June 18, 2012, Petitioner was a 65-year-old building and grounds maintenance serviceman for Respondent, Central Management Services, at the DuQuoin State Police office. (T.7). On that date, Petitioner was laying on his side and removing blades from a tractor when he encountered a difficult bolt and began applying pressure on the bolt with his right shoulder. (T.8). When the bolt gave way, Petitioner felt a pop in his right shoulder. (T.8). Petitioner testified that he gave notice of the injury to the building engineer, Jerry Cryan. (T.8). The Supervisor's Report of Injury or Illness completed by Mr. Cryan on September 18, 2012, states that Petitioner orally notified his supervisor of the accident as described in his testimony on the same date of its occurrence, June 18, 2012. (RX3). The Supervisor's Report indicates that the accident occurred while changing blades on a tractor used for mowing, and that the "bolts were tight and when they broke loose, caused sudden jerk on shoulders [sic]." *Id.* Respondent does not dispute notice. (AX1).

Petitioner attempted to continue working following the 18 June 2012 accident with the use of over-the-counter medication; however, his condition deteriorated until his shoulder was too weak and too limited in range of motion for him to work. (T.10-11). Petitioner testified without rebuttal that he did not sustain any intervening accidents between the accident on June 18, 2012, and September 24, 2012, the date he saw Dr. Davis. (T.11). Petitioner previously saw Dr. Davis for a right shoulder sprain in 1994 and a left shoulder strain in 1998. (RX8, 3/10/94, 1/23/1999).

Petitioner candidly testified to a prior workers' compensation claim in 1998 in which he claimed bilateral shoulder injuries. (T.9). However, he did not undergo any surgery as a result of that accident, and after receiving conservative care for that accident, he required no further care

or treatment for his right shoulder up until the accident on June 18, 2012. (T.9-10). Petitioner managed his occasional symptoms with over-the-counter Motrin. (T.10). The records of the prior accident in 1998 submitted by Respondent corroborate Petitioner's testimony and show that Petitioner only required minor conservative treatment for his *left* shoulder. (RX8). Petitioner's testimony at Arbitration demonstrates that he had no recollection of Dr. Davis previously examining his right shoulder; however, the Arbitrator does not find it unreasonable for Petitioner to have no recollection of a single office visit that occurred 20 years ago in March of 1994. (T.27).

Petitioner first sought treatment with a nurse assistant in the office of his family physician, Dr. Fozard, on 4 September 2012 and did not give any history of an injury, as he did not know what, if anything, was wrong. (PX4, 9/4/12). X-rays were ordered and showed negligible degeneration and no signs of fracture, dislocation or bony destruction. (PX5, 9/4/12). However, the MRI of Petitioner's right shoulder obtained three days later on September 7, 2012, at Cedar Court Imaging revealed a full-thickness rotator cuff tear and a partial tear possibly extending further in the anteroposterior (AP) direction. (PX6).

After he received the results of his MRI on September 7, 2012, and his symptoms continued to worsen following the visit on September 4, 2014, the nature of the injury and its relation to work became apparent to Petitioner and his physicians. Petitioner spoke with the nurse assistant again and was referred to Dr. Davis. (T.11-12). Petitioner testified that the worsening of his symptoms were gradual up until the time he saw Dr. Davis, and that he spoke to a nurse who referred him to Dr. Davis. (T.11). The 4 September 2012 treatment record from Dr. Fozard does not document a referral and only contains instructions to follow up within 1 week. (PX4, 9/4/12). There is no record of a follow-up visit until December of 2012, and the record is clear that Petitioner was referred to Dr. Davis by Dr. Fozard's office. (PX4; PX9, p.8). The treatment record for the visit on 4 September 2012 was printed on September 17, 2012, (see the date and time stamp of printing under the electronic signature), and Dr. Davis addressed his 24 September 2012 treatment record to Dr. Fozard's office expressing thanks to Dr. Fozard for requesting a consultation for Petitioner. (PX3, 9/24/12; PX4, 9/4/12). Petitioner completed an Employee's Notice of Injury on September 17, 2012, and a "Demands of the Job" form was created on the same day. (RX2; RX4). The Supervisor's Report of Injury or Illness was completed on September 18, 2012, and noted the September 7th MRI result of "torn rotator cuff of right shoulder" under the description of injury. (RX3). Accordingly, the only reasonable factual conclusion is that at some point between September 7, 2014, and September 17, 2012, Petitioner and his doctors realized the cause of his symptoms, called his physician's office and requested to see the shoulder specialist who treated him in the past, and notified Respondent of his need for treatment through workers' compensation on September 17, 2012. (T.11-12; PX3, 9/24/12; PX4, 9/4/12; RX2; RX3; RX4).

Consequently, when Petitioner saw Dr. Davis on September 24, 2012, he reported that his current problem [the rotator cuff tear] began on June 18, 2012. (PX3, 9/24/12, Intake

Questionnaire). Dr. Davis took the history of Petitioner being injured when he felt a pop in his right shoulder while changing blades on a tractor at work. (PX3, 9/24/12). Dr. Davis also noted that Petitioner had no prior shoulder surgeries. *Id.* Physical examination demonstrated tenderness to palpation over the anterior and lateral biceps tendon with no crepitus. Neer's and Hawkin's tests were positive for rotator cuff pathology, and Petitioner reported pain on range of motion. *Id.* Dr. Davis assessed right shoulder impingement with a torn rotator cuff of the right shoulder. *Id.* Conservative management was recommended and Petitioner was given a cortisone injection. *Id.* Petitioner was taken off work and referred for physical therapy. *Id.* However, Petitioner was motivated to work; he subsequently called Dr. Davis, expressed an earnest desire to work and was given clearance to work with restrictions on October 3, 2012. (PX3, 10/2/12).

Petitioner returned to Dr. Davis on 29 October 2012 with persistent discomfort ranging from 2 to 6 on a scale of 10 depending upon his level of activity. (PX3, 10/29/12). Since Petitioner failed to improve with conservative care, Dr. Davis recommended surgery. *Id.* Dr. Davis performed arthroscopic surgery on Petitioner's right shoulder consisting of diagnostic debridement of the anterior glenoid labrum and biceps tendon, acromioplasty with arch decompression and open repair of the supraspinatus tendon of the rotator cuff on November 27, 2012. (PX8). Dr. Davis referred Petitioner for physical therapy. (PX3, 12/10/12). Petitioner reported improvement in discomfort with physical therapy on January 7, 2013; however, additional physical therapy was required to increase range of motion and improve weakness. (PX3, 1/7/13, 2/18/13). Dr. Davis believed it would take 9 months for a full recovery. (PX3, 2/18/13). Petitioner returned to work without restrictions on March 5, 2013. (T.13; PX3, 2/18/13 Work Status).

On April 1, 2013, Petitioner returned to his family physician and reported continued pain in his right shoulder. (PX4, 4/1/13). Petitioner returned to Dr. Davis on April 15, 2013, and reported that he still had pain up to a 4 or 5 on a scale of 10 with everyday use of his right shoulder despite the improvement over the last four-and-a-half months. (PX3, 4/15/13). Petitioner continued to engage in home strengthening exercises, and Dr. Davis recommended lifting precautions at work of no lifting over 20 pounds. *Id.* Petitioner reported on 15 July 2013 that he has pain at night if he lies on his right side as well as mild residual pain day in and day out. (PX3, 7/15/13).

Although Petitioner testified that surgery improved his strength, he continues to suffer from limited range of motion and residual pain. (T.13-16). Petitioner testified that he experiences pain more frequently than he did before the accident. (T.16). Before the accident, he took Motrin once or twice per week; now he takes Motrin twice a day. (T.16). When asked to compare his pre and post-accident condition, he stated:

> Well, before – it's kind of hard to explain – the pain was there, but it didn't last very long. I mean it was just stretched tendons. You would get some rest, and it would pretty well come back, and then I would have off and on pain if I

> move. If I done a lot or something like that, it would just kind of ache a little bit, take some Motrin it was gone; but I never lost the strength in it like I did on this one (indicating). When I go to pick up 10, 15 pounds, I couldn't lift it. (T.14).

Petitioner expressed confidence in continued improvement in strength and could lift up to 20 pounds at the time of the hearing, but he did not testify to any current or prospective improvement in range of motion. (T.14-15). Petitioner testified that he did not have any loss in range of motion in his right shoulder prior to the June 18, 2012 accident. (T.15). He demonstrated his loss in range of motion and pain with motion before the Arbitrator and described it as follows:

> Q: Describe for the Court your current range of motion. What parts – what ranges do you have forward, backwards?
>
> A: It's both, backwards and sideways most. I can go up here (indicating), and I'm starting to feel pain. I can push it on up, but that's it. If I go sideways right here is about as far back as it goes. If I go back here, belt level is as high as I can go with it backwards. (T.15).

Petitioner's golfing hobby has been adversely affected. (T.16).

Petitioner testified that his job requires him to occasionally lift over 20 pounds when he receives a special order item such as furniture. (T.19). Respondent's Demands of the Job form indicates that Petitioner performs lifting up to 100 pounds as well as pushing and hand trucking. (RX4). It does not indicate the weight that Petitioner is required to push with a hand truck. (RX4).

Respondent did not have Petitioner examined. (T.12-13).

Petitioner's shoulder surgeon, Dr. Davis, testified by way of deposition on April 17, 2014. (PX9). Dr. Davis is board certified in orthopedic surgery. (PX9, p.5). Dr. Davis testified that he saw Petitioner at the referral of Dr. Fozard. *Id.* at 8. Dr. Davis testified that despite non-operative measures such as physical therapy and injection, Petitioner only experienced temporary relief from the symptoms of weakness and pain, which were characteristic of the rotator cuff tear shown on the 7 September 2012 MRI. *Id.* at 6. He testified that Petitioner had not sustained any new trauma to his right shoulder from the time he began treating him. *Id.* at 7.

Dr. Davis testified that during surgery, he identified a full thickness rotator cuff tear involving primarily the supraspinatus tendon, which correlated with Petitioner's physical examination findings and MRI findings. *Id.* at 7. Petitioner made slow but satisfactory progress following surgery. *Id.* at 7.

Dr. Davis testified without rebuttal that the mechanism of injury as described by Petitioner is entirely consistent with rotator cuff injury. *Id.* at 9-10. He testified without rebuttal

that struggling to release bolts on a lawnmower blade would cause and contribute to Petitioner's rotator cuff tear, his need for treatment including surgery, and his time off work. *Id.* at 9-10.

On cross-examination, Respondent questioned Dr. Davis concerning the natural progression of rotator cuff pathology. *Id.* at 14. While Dr. Davis testified that it was possible for rotator cuff *pathology* to develop with age, spurring or osteophyte formation; he stated there is frequently an inciting event that converts the rotator cuff *pathology* into a complete *tear*. *Id.* at 14. Thus, Petitioner's rotator cuff *tear* would be a combination of degeneration *and trauma*. *Id.* at 14.

CONCLUSIONS OF LAW

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

The word 'accident' is not a technical legal term and has been held to mean anything that happens without design, or an event which is unforeseen by the person to whom it happens. *Laclede Steel Co. v. Indus. Comm'n*, 6 Ill. 2d 296, 300, 128 N.E.2d 718, 720 (Ill. 1955). An injury is accidental within the meaning of the Act when it is traceable to a definite time, place and cause, and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Id.* An injury is also accidental within the meaning of the Act if "a workman's existing physical structure, whatever it may be, gives way under the stress of his usual labor." *Id.*

The "arising out of" component is primarily concerned with causal connection. *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 58, 133 Ill.Dec. 454, 541 N.E.2d 665 (Ill. 1989); *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203-04, 797 N.E.2d 665, 672 (Ill. 2003). 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. [Citations]. Stated otherwise, "an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he had a common law or statutory duty to perform, or acts which the employee might reasonably be expected to perform incident to his assigned duties. [Citations]. A risk is incidental to the employment where it belongs to or is connected with what an employee has to do in fulfilling his duties." *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d at 58, 133 Ill.Dec. 454, 541 N.E.2d 665; *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill. 2d 193, 203-04, 797 N.E.2d 665, 672 (Ill. 2003).

The Arbitrator finds that there is no question as to whether or not the lawnmower blade removal accident as described by Petitioner occurred on June 18, 2012. Respondent purportedly disputes accident on the basis that Petitioner made no mention of the lawnmower blade accident to his family physician on September 4, 2012; the first description of the accident appeared in

Dr. Davis' note of 24 September 2012. However, the Supervisor's Report of Injury submitted by Respondent documents that oral notice of the incident was received by Petitioner's supervisor approximately 30 minutes after it occurred, and the supervisor's description of the accident is entirely consistent with Petitioner's testimony and Notice of Injury. (T.7-8; RX2; RX3). Petitioner, therefore, unquestionably sustained and reported an incident to his employer well before he saw his family doctor on September 4, 2012. Although he may have questioned the *extent* of his injury and his *need for treatment*, Petitioner clearly traced his accident to a definite time, place and cause. The Arbitrator also notes that the performance of the repair activity which caused injury was incidental to Petitioner's employment and occurred within the course and scope of his job duties. The Supervisor's Report of Injury confirms same. (RX3). Therefore, the Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of his employment with Respondent on June 18, 2012.

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

An injury need not be the sole factor, or even the primary factor of an injury, as long as it is a causative factor. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665, 672-73 (Ill. 2003) [Emphasis added]. 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, 592, 834 N.E.2d 583, 592 (2d Dist. 2005). In fact, "[*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 (3d Dist. 2000). 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 (1st Dist. 1999) citing *General Electric Co. v. Industrial Comm'n*, 89 Ill.2d 432, 434, 433 N.E.2d 671, 672 (Ill. 1982). Therefore, a claim will not be denied simply because of a preexisting condition; if the condition is aggravated, accelerated, or exacerbated, the claimant is entitled to benefits. *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 205, 797 N.E.2d 665, 672-73 (Ill. 2003).

Documentary and circumstantial evidence, especially when entirely in favor of the Petitioner, is sufficient to prove a causal nexus between an accident and the resulting injury. *Gano Electric Contracting v. Industrial Comm'n,* 260 Ill.App.3d 92, 96–97, 631 N.E.2d 724, 728 (4th Dist. 1994); *International Harvester v. Industrial Comm'n,* 93 Ill.2d 59, 442 N.E.2d 908 (Ill. 1982). A causal connection between work duties and a condition may be established by a chain of events including [P]etitioner's ability to perform the duties before the date of the accident, and inability to perform the same duties following that date. *Darling v. Indus. Comm'n of Illinois*, 176 Ill.App.3d 186, 193, 530 N.E.2d 1135, 1140 (1st Dist. 1988). The Arbitrator notes that the record is void of any intervening or accidents or alternative causes for Petitioner's right shoulder complaints and his time off work as a result thereof.

The Arbitrator finds no discrepancy between the Petitioner's report of a one-year history of right shoulder problems given to Dr. Fozard's assistant, and the report to Dr. Davis that his "current" problem began with the incident on June 18, 2012. (PX3, 9/4/12; PX4, 9/24/12). Petitioner candidly testified to mild symptoms in his right shoulder prior to the accident on June 18, 2012; however, these responded to over-the-counter medication. (T.9-11, 16). Hence, Petitioner's history to his family physician is not unreasonable. However, the Arbitrator finds it noteworthy that Petitioner was working without any problems of weakness prior to the accident of June 18, 2012, and the prior records show that Petitioner only necessitated prescribed conservative care for his left shoulder as a result of the work injuries he sustained nearly two decades ago. (T.9-11, 14). Since Petitioner gave *oral* notice of his injury *on the date of the accident* and did not provide written notice of his injury until *after he discovered that he had sustained a rotator cuff tear and his condition worsened* (T.11), it can be reasonably inferred that Petitioner simply believed that he had only sustained perhaps a temporary sprain or exacerbation of his symptoms that would resolve without incident. The Arbitrator thus finds Petitioner's testimony that he did not report the injury because he "never really paid much attention to it" to be credible. (T.26).

Petitioner's prior medical records submitted by Respondent are silent with regard to any right shoulder complaints requiring treatment for 20 years, and these same records are clear that the only injuries sustained were **sprains/strains**. (RX8). **When Petitioner saw Dr. Davis on September 24, 2012, he had obtained the results of the 7 September 2012 MRI and was fully aware that he "currently" suffered from a rotator cuff tear, which his prior medical records prove that he did not have before.** Thus, Petitioner's report to Dr. Davis that his *"current" problem began on 18 June 2012* is credible and supported by the evidence in the record. Petitioner subsequently reported to Respondent that the "MRI shows torn rotator cuff," and informed Dr. Davis of the precipitating incident on September 24, 2014. (RX2). Based on Petitioner's lack of problems prior to the accident, and his unrebutted history of gradually progressing symptoms since the accident on June 18, 2012, the Arbitrator finds that the circumstantial evidence preponderates in Petitioner's favor.

Petitioner also presented the unrebutted causation opinion of Dr. Davis to establish causal connection. (PX9). The Arbitrator finds his opinion that Petitioner's current condition of ill-being is related to Petitioner's accident on 18 June 2012 to be credible. The Arbitrator is not persuaded by Respondent's position that Petitioner's rotator cuff tear is the result of degeneration. First, the evidence does not support such a conclusion, and second, Respondent failed to have Petitioner examined under §12 of the Act and present any evidence to support its position. The Arbitrator notes that Petitioner's x-ray only demonstrated inconsequential findings of degeneration which were characterized as "mild" and "minimal." (PX5, 9/4/12). Petitioner's degenerative findings on MRI were also mild. (PX6). The MRI reported "*small* joint effusion compatible with degenerative change," and Petitioner's acromioclavicular joint space was perfectly preserved despite bone spurs. (PX6). Dr. Davis testified that even though rotator cuff

pathology can occur with age, a *traumatic event* is often required to form a *tear.* (PX9, p.14). Thus, he believed that the traumatic event was required to result in Petitioner's rotator cuff tear. Petitioner's mild degenerative findings and lack of treatment prior to the accident simply do not support Respondent's position that Petitioner's tear occurred solely as the result of degeneration. Therefore, the preponderance of the evidence supports Petitioner's position that the accident on 18 June 2012 was the precipitating traumatic event that resulted in the rotator cuff tear and the requisite medical treatment.

Petitioner testified that he attempted to continue working following the accident with the use of over-the-counter medication; however, his condition deteriorated until his shoulder was too weak and too limited in range of motion for him to work. (T.10-11). The Arbitrator notes that the record shows that Petitioner lacked a complaining spirit, was driven to return to work, and faithfully participated in his physical therapy program at work and at home to improve his condition. (PX3, generally, 10/2/12; PX5). Petitioner demonstrated the same positive attitude at Arbitration and testified to his continued efforts to improve his strength. (T.14-15). The Arbitrator declines to penalize an employee who diligently worked through his progressive symptoms until he required treatment. *Durand v. Indus. Comm'n*, Ill. 2d 53, 74, 862 N.E.2d 918, 930 (Ill. 2006). The Arbitrator finds that Petitioner's current condition of ill-being is causally related to his accidental injury which occurred on June 18, 2012.

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): What temporary benefits are in dispute? (TTD)

Respondent only disputed liability for medical bills and temporary total disability benefits based on its dispute of accident and causal connection. Based upon the above findings resolving these issues in Petitioner's favor, the Arbitrator hereby awards the medical expenses contained in Petitioner's group exhibit and temporary total disability benefits for 14 weeks for Petitioner's period of disability from November 27, 2012 through March 4, 2013. Respondent shall have credit for any amounts paid to Petitioner's medical providers through its group carrier pursuant to §8(j) of the Act, and shall have credit for the temporary total disability benefits which Petitioner stipulated were paid.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 are to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of the Act; (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; and (v) evidence of disability corroborated by the treating medical records. 820 ILCS

305/8.1b. The Act provides that, "No single enumerated factor shall be the sole determinant of disability." 820 ILCS 305/8.1b(b)(v).

(i) **Level of Impairment**: Neither Party submitted an AMA rating. Therefore, the Arbitrator will consider the remaining factors to evaluate Petitioner's permanent partial disability.

(ii) **Occupation**: Petitioner remains employed by Respondent as a grounds maintenance serviceman. The Arbitrator notes that Petitioner's job is arm intensive and places a heavy demand on Petitioner's right shoulder. (RX4). Petitioner works on heavy machinery for up to 4 hours per day and performs lifting up to 100 pounds. (RX4). Accordingly, the Arbitrator places great weight on this factor.

(iii) **Age**: Petitioner was 67 years old at the time of his injury. He is advanced in age and has diminished healing capacity as a result thereof. Accordingly, the Arbitrator places great weight on this factor.

(iv) **Earning Capacity**: While there is no direct evidence of reduced earning capacity contained in the record, based on the severity of Petitioner's injuries, the requisite surgical treatment, Petitioner's advanced age and his residual disability, it is reasonable to conclude that such repercussions will manifest in the near future.

(v) **Disability**: As a result of his accidental injury, Petitioner sustained a rotator cuff tear which proved refractory to conservative care and necessitated surgery consisting of diagnostic debridement of the anterior glenoid labrum and biceps tendon, acromioplasty with arch decompression and open repair of the supraspinatus tendon of the rotator cuff. (PX8). Although Petitioner testified that surgery improved his strength, he continues to suffer from limited range of motion and residual pain. (T.13-16). Petitioner testified that he experiences pain more frequently than he did before the accident. (T.16). Before the accident, he took Motrin once or twice per week; now he takes Motrin twice a day. (T.16). Despite the improvement in his strength, Petitioner continues to suffer significantly limited range of motion and pain on range of motion, which was demonstrated for the Arbitrator (T.14-15). Petitioner testified that he did not have any loss in range of motion in his right shoulder prior to the June 18, 2012 accident. (T.15). Petitioner's golfing hobby has been adversely affected. (T.16).

Based upon the foregoing factors, the Arbitrator finds that Petitioner sustained serious and permanent injuries that resulted in the 12.65% loss of his personal as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON/)
SANGAMON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Everett Ayres,
Petitioner,

15IWCC0614

vs.

NO: 12WC 39746
12WC 39747
12WC 44647

State of Illinois, Alton Mental Health,
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, incurred medical, prospective medical, notice and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

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

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

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

DATED:
o080515
CJD/jrc
049

AUG 1 1 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

AYRES, EVERETT
Employee/Petitioner

Case# **12WC039746**

12WC039747
12WC044647

SOI/ALTON MENTAL HEALTH
Employer/Respondent

15IWCC0614

On 1/14/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

JAN 14 2015

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

15IWCC0614

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison/Sangamon)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Everett Ayres
Employee/Petitioner

v.

State of Illinois, Alton Mental Health
Employer/Respondent

Case # **12** WC **39746**

Consolidated cases: **12 WC 39747, 12 WC 44647**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the cities of **Mt. Vernon and Springfield**, on **November 7, 2014, and November 12, 2014, respectively.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [x] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [x] Was timely notice of the accident given to Respondent? (D/A: 8.16.12 and 2.20.12 only)
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [x] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] Is Petitioner entitled to any prospective medical care?
L. [ ] 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 (12 WC 39746 -- D/A: 8.11.10)

On the date of accident, **August 11, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

Petitioner's earnings during the year preceding the accident were **$92,918.40**; his average weekly wage was **$1,945.58.**

On the date of accident, Petitioner was **62** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**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 general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

FINDINGS (12 WC 39747 -- D/A: 2.20.12)

On the date of accident, **February 20, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**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 general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

FINDINGS (12 WC 44647 -- D/A: 8.16.12)

On the date of accident, **August 16, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

On the date of accident, Petitioner was **64** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**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 general credit for any medical bills paid by its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Case # 12 WC 39747 and 12 WC 44647:

Petitioner failed to prove he sustained an accident on February 20, 2012 or August 16, 2012 that arose out of and in the course of his employment or that his current condition of ill-being in his left heel/ankle is causally related to either of those alleged accidents. Petitioner's claims for compensation in 12 WC 39747 and 12 WC 44647 are denied and no benefits are awarded.

Case # 12 WC 39746:

Respondent shall pay reasonable and necessary medical services of $300.00, as provided in Section 8(a) of the Act. Respondent shall have credit for any payments that have been made on those expenses, but shall indemnify and hold Petitioner harmless from any claims arising from the medical expenses for which it claims credit.

Petitioner failed to prove his current condition of ill-being in his left heel/ankle is causally related to his August 11, 2010 accident and Petitioner's claim for other benefits, including prospective medical care, is denied.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any, in case number 12 WC 39746.

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.

Mary Kendray
Signature of Arbitrator

January 9, 2015
Date

ICArbDec19(b)

JAN 14 2015

Everett Ayres v. State of Illinois/Alton Mental Health Center
D/A: 8/11/10, 12 WC 39746
D/A: 8/16/12, 12-WC-39747
D/A: 2/20/12, 12-WC-44647

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Petitioner has three Applications for Adjustment of Claim pending against Respondent. Claim number 12-WC-39746, alleges that on August 11, 2010 Petitioner twisted and cut his left foot/ankle and leg during a fall (AX 2); claim number 12-WC-39747, alleges that on August 16, 2012 Petitioner suffered an aggravation of a pre-existing condition to his left foot/ankle, left leg pushing 500 lb. carts (AX 3). Case number 12-WC-44647 alleges that on February 20, 2012 Petitioner suffered an aggravation of a pre-existing condition to his left foot/ankle, left leg pushing 500 lb. carts (AX 4). All three cases were consolidated for purposes of hearing with the parties requesting that only one decision be issued.

Petitioner's cases proceeded to hearing pursuant to Section 19(b) of the Act. As the record will reflect these cases were tried over a period of two days and under some extenuating circumstances. The disputed issues were: accident; notice with regard to the 2/20/12 and 8/16/12 injuries; causal connection; Petitioner's earnings; medical bills; and prospective medical care. Petitioner was the sole witness testifying in his behalf at arbitration. Ms. Valerie Hall and Mr. Randy Ellis testified on behalf of Respondent.

The Arbitrator finds:

Petitioner was employed by Respondent, Alton Mental Health, as a Stationary Engineer for approximately fourteen (14) years before he retired in December of 2012. Prior to his employment with Respondent, Petitioner was employed by SIUE, Northwestern Joint Action Agency in Chicago, the City of Highland, the New York Central Railroad, the Pennsylvania Railroad and the Conrail. Petitioner began his working career in 1966. Petitioner testified that, until 2012, he had never filed a formal workers' compensation claim. Petitioner's job duties for Respondent entailed performing road repair, grounds work, welding, fabrication and electrical work, servicing heating, air conditioning and plumbing, and repairing water main breaks, sewer blockage, and roof damage.

On August 11, 2010, while in the course of his duties, Petitioner was called to the Holly building located at Respondent's facility to repair an air conditioner. While working to repair an air conditioner he fell going up some stairs.

On August 12, 2010 Petitioner reported his injury. Petitioner's Exhibit 6 contains Petitioner's Report of Injury for the August 11, 2010 accident. It documents "worker was carrying his tools to the roof to check on the air handler and he missed a step and fell, cutting his lower left leg." Another report states that Petitioner "trip[ped] with tool bags on steps" and reported an injury to the left leg below the knee, a cut. The report indicates that Petitioner did not report the injury on the date of the accident because he "didn't think it would be a problem."

The Form 45 states that Petitioner had a puncture wound the size of a quarter on his left lower leg." (PX 6; RX 1)

On August 12, 2010, Petitioner presented to St. Anthony's Health Care Center where he was treated for swelling and a scar on his left leg after hitting his shin while ascending up stairs at work the day before. Several pain drawings included in the records indicate the area of redness and swelling. Petitioner's ankle was not marked. Petitioner's physical examination included the foot, ankle, knee, and leg with only objective findings being noted on Petitioner's left leg (redness, swelling, and a scab). An x-ray of Petitioner's left leg was negative. Petitioner was diagnosed with a contusion of the left leg, prescribed antibiotics and released with instructions to see his primary care physician, Dr. Alvarado, the next day. (PX 3; PX 6; RX 4)

There is nothing in the medical records indicating Petitioner followed up with Dr. Alvarado the next day as advised. Petitioner continued working full duty for Respondent.

There is no record of any medical treatment to Petitioner's left lower extremity between August 12, 2010 and February 20, 2012. However, during this time Petitioner was periodically examined by his primary care physician, Dr. Alvarado. Petitioner went to Dr. Alvarado on 8/23/2010. (RX 5) While Petitioner was at that appointment for his routine medical conditions (high blood pressure, hypertension, cholesterol), Dr. Alvarado also noted the Petitioner still had some cellulitis to his left shin and so he prescribed him a "few more days of antibiotics." Dr. Alvarado noted the Petitioner did not have any muscle, joint or bone pain and that he did not have any clubbing, cyanosis or edema in his extremities. There are no references in Dr. Alvarado's 8/23/2010 notes to Petitioner's left foot, heel or ankle. (RX 5)

Petitioner again saw Dr. Alvarado on January 27, 2011 and October 20, 2011 and did not report any left leg/foot symptoms. (RX 5) On those dates, Dr. Alvarado noted that Petitioner did not have any clubbing, cyanosis or edema in his extremities and did not have any abnormalities in his musculoskeletal system. Petitioner was treated for Cholesterol, Hyperlipidemia High Cholesterol, Hypertension, Psoriasis, Obstructive Sleep Apnea, Obesity, and Fatigue, but there is no mention of his left foot at all. (RX 5)

On May 12, 2011 Petitioner suffered a chemical burn to his right hand while cleaning compressors. (RX 2)

On February 10, 2012 Petitioner saw Dr. Alvarado, who noted that Petitioner had general arthritic changes, but a normal gait. Again, Petitioner had no diagnoses or treatment with regard to his left foot. (RX 5)

On February 20, 2012, Petitioner sought treatment with Dr. Aquino, a podiatrist, who noted:

> Mr. Ayres is a 64 year 2 month old male complains [sic] of pain and discomfort at the posterior aspect of the heel. It is located on the left heel. It started several years ago. Usually lasts for several hours. It occurs intermittently. He describes the pain as acute and

> aching in nature. The pain is better with rest and altering shoe gear. Aggravating factors are prolonged standing and or walking and shoes. It was precipitated by a fall on steps at work where his ankle swelled and had a cut that required hospital care and was later aggravated by his new duties when he was pushing 500 lbs. carts. No previous occurrence of a similar problem. Everett has not tried any form of treatment for the current condition.

On examination, Dr. Aquino noted pain at the posterior aspect of the heel at the insertion of the Achilles tendon. Pain was elicited with dorsiflexion of the foot. A bony prominence was palpable on the posterior aspect of the calcaneus and swelling was noted. X-rays reviewed a posterior calcaneal exostosis at the attachment of the Achilles tendon. Dr. Aquino recommended that Petitioner "continue" with immobilization and utilize the pneumatic cam walker he already owned. Petitioner was diagnosed with a calcaneal spur and tendinitis/bursitis of the achilles. Dr. Aquino also prescribed Naprosyn. (PX 4)

On March 12, 2012, Petitioner returned to Dr. Aquino and moderate improvement was noted. Findings on physical examination remained essentially the same and Petitioner was instructed to continue with immobilization. (PX 4)

On August 13, 2012, Petitioner returned to Dr. Aquino and reported no improvement. Petitioner's findings on physical examination remained essentially the same. Dr. Aquino recommended an ankle brace (multiligamentous ankle support) to the left foot and dispensed the device to limit motion and provide stabilization of Petitioner's ankle joint. Petitioner was also prescribed a Medrol Dosepak, a steroid anti-inflammatory medication. (PX 4)

Petitioner was seen at Dr. Alvarado's office on August 30, 2012, regarding refills for blood pressure and cholesterol medications. No left lower extremity complaints were noted. (RX 5)

On September 17, 2012, Randy Ellis sent an e-mail to Petitioner confirming his understanding (through a discussion with Floyd Fessler) that Petitioner was going to see his doctor that evening. Mr. Ellis requested a slip from Petitioner conveying his refusal to drive and deliver food carts. (PX 8)

Petitioner initially made an appointment to do so on September 17, 2012. An excuse slip dated September 17, 2012 from Dr. Aquino states:

> This is to certify that Everett Ayres (has/had) an appointment at this office for professional attention on 9/17/2012 at 04:20 PM o'clock. Due to a family emergency Dr. Aquino was unavailable to evaluate Everett today. Patient was asked to return on 9/20/12 at 10 am for further evaluation. A restriction letter will be faxed within the next few days. (PX 4)

Petitioner was then seen by Dr. Aquino on September 20, 2012 with moderate improvement in his symptoms being noted. Examination findings remained essentially the same, with continued pain on palpation of the posterior aspect of the heel at the insertion of the Achilles tendon, a bony prominence palpable on the posterior aspect of the calcaneus, and swelling. Dr. Aquino recommended that Petitioner continue to use the ankle brace and refrain from pushing heavy carts at work as Petitioner noticed increased pain in his heel when doing so and was at risk of an Achilles tendon rupture. Dr. Aquino authored a "Restriction Work Slip" that stated:

> This is to certify that my patient, Everett Ayres, is under my care for Achilles Tendinitis on his left foot. I have recommended that the patient continue to utilize his ankle brace. He is experiencing increased pain in the posterior heel at the insertion of the Achilles tendon.
>
> I would like for him to refrain from pushing heavy carts at work. He is at risk of an Achilles Tendon Rupture, if these activities continue. This restriction is until further notice, effective as of today 9/20/12. (PX 4)

On September 21, 2012 Petitioner and Randy Ellis acknowledged/verified an "Interoffice Correspondence" dated September 17, 2012 regarding the responsibilities of a stationary engineer. (PX 8)

Petitioner applied for a leave of absence pursuant to the Family Medical Leave Act (FMLA) on September 21, 2012. (PX 7)

On October 10, 2012, Petitioner returned to Dr. Aquino. A second ankle brace was dispensed and Petitioner was noted to continue to take Naprosyn and Medrol Dosepak. (PX 4)

During October of 2012 Petitioner took photographs of the stairs where he fell in August of 2010. (PX 10)

On October 31, 2012 Petitioner was issued a Memorandum from CMS regarding a "Pre-Disciplinary Meeting" to be held on November 5, 2012 regarding "inefficiency and inattention in performing a duty and disrespect toward a supervisor." The Memorandum includes a list of reasons discipline for Petitioner was being considered including, inter alia, his reluctance to follow through on job assignments and sarcastic comments over the radio as well as comments regarding taking pictures on DHS property. (PX 15) E-mail correspondence documenting the charges is attached. (PX 15)

On/about November 2, 2012 Petitioner requested time off from work on November 2 and 5, 2012. Petitioner's request for time off was approved and he was advised that Floyd Fessler would be representing him at the hearing on the 5th. Petitioner was encouraged to be present. (PX 15)

Petitioner was seen again by Dr. Aquino on November 5, 2012. Petitioner reported a 50% improvement of his condition and his physical examination remained essentially the same. Petitioner continued to use the ankle brace and was advised to continue to refrain from pushing heavy carts at work. (PX 4)

On November 7, 2012 Respondent received a letter from Petitioner's attorney enclosing Applications for Adjustments of Claim for accident dates of August 11, 2010 and September 17, 2012. With regard to the September 17, 2012 accident Petitioner claimed an "aggravation of pre-existing condition to his left foot/leg." (RX 3)

On November 13, 2012 Dr. Aquino took Petitioner off work as of November 14, 2012 through January 2, 2013 due to his foot problem. (PX 4)

On November 15, 2012 Petitioner's Applications for Adjustment of Claim in 12 WC 39746 (D/A: 8/11/10) and 12 WC 39747 (D/A: 9/17/12) were filed.

Petitioner again applied for FMLA leave on November 14, 2012. (RX 6) Respondent's Exhibit 6 contains a CMS-1021-CFE filled out by Dr. Aquino on November 13, 2012, that is apparently part of the FMLA application. Dr. Aquino reported that Petitioner was being treated for increased heel pain and swelling. Petitioner was instructed to refrain from working activity for 6 weeks because of his risk of Achilles Tendon Rupture. Dr. Aquino reported that Petitioner would have episodic flare-ups preventing him from performing his job functions because "due to employee work activities he is at risk for an Achilles Tendon Rupture due to his current condition." (PX 7; PX 6)

On December 5, 2012, Petitioner returned to Dr. Aquino and was given a new pneumatic cam walker. On December 10, 2012, Petitioner returned and physical findings remained consistent. Dr. Aquino recommended continued immobilization, an ankle brace, and found that Petitioner was still at risk of an Achilles Tendon Rupture. (PX 4)

On December 11, 2012, Petitioner presented to his primary care physician, Dr. Alvarado, with the chief complaints of a painful front left shin. Petitioner reported that the front of his left shin hurt all the way down to the bone and that he had a "balled up" muscle down by the ankle due to an injury at work two years earlier. Nurse practitioner Collman noted," Petitioner complains of musculoskeletal pain. This was first noted 2 months ago, was insidious in onset, had infection in wound to left shin and this lasted 'for months." Now there is numbness with pain as if 'cut never healed.' Has been seeing podiatrist for several weeks. Has had steroid use and light therapy." Nurse practitioner Collman noted she wished to see information from the podiatrist. The office notes contain a description of Petitioner's left lower extremity:

> There is a small indent in the skin of the shin midline 5 cm above lateral ankle and a bulge 9 cm above lateral ankle. There is a discoloration from varicosity under the skin midline shin. Has a solid mass at the Achilles tendon insertion about the size of a golf ball. 5.5 cm wide and 4.5 cm high. Pulses at the achilles and the dorsa pedalis normal in the left leg. Capillary refill is normal < 5

> sec. Foot is warm to touch, no redness. The mass in the back of the foot is fixed position. P[atient] has decreased sensation over the toes and bottom of the foot. P[atient] is wearing a supportive boot that received from podiatrist. (PX 5, p. 4)

Petitioner's recent memory was noted to be somewhat impaired and Petitioner has difficulty reporting past events and remembering recent events." He was, however, oriented to person, place and time. (PX 5, p. 4) A referral to an orthopedic specialist and to the previous "healing doctor" was noted. Petitioner was to return in one month or sooner, if necessary. (PX 5)

Petitioner was re-examined at Dr. Alvarado's office on November 28, 2012, mainly for refills of blood pressure medications, cholesterol and Plavix. It was noted he needed to see his cardiologist again. Petitioner had recently been to the emergency room (November 23rd) for an eye abrasion. Discussion was held regarding Petitioner's sleep apnea, hypertension, shortness of breath, hyperlipidemia, weight, and memory issues. Petitioner "has had issues with memory. Seems to be forgetful. Misplaces things at work, but this is not normal for [him]." (RX 5) Petitioner noted that his wife wanted him evaluated for memory issues. According to the office note, "[Petitioner] states is having short term memory recall of events as well. What he recently did, what he may have recently said." (RX 5) There is no mention of Petitioner's left lower extremity. (RX 5)

On December 21, 2012 Petitioner's attorney sent an Application for Adjustment of Claim alleging an accident date of February 20, 2012 to the Illinois Workers' Compensation Commission for filing. Petitioner claimed an injury of "aggravation of pre-existing condition" to his left foot/leg. (RX 3) That same day, Petitioner, through his attorneys, sent an Application for Adjustment of Claim regarding an accident date of 5/12/11 to the Illinois Workers' Compensation Commission for filing. Copies of the foregoing were sent to Respondent. (RX 3)

On December 31, 2012 Petitioner filed his Application for Adjustment of Claim in 12 WC 44647 with an accident date of February 20, 2012. Petitioner alleged aggravation of a pre-existing condition in his left foot, ankle, and leg.

Petitioner retired at the end of 2012.

On February 21, 2013, Petitioner returned to Dr. Alvarado for refills of his blood pressure, cholesterol, and Plavix medications, and for ringing in his ears and labs. On examination, Dr. Alvarado noted that Petitioner's gait demonstrated limping on the left leg with the use of a stabilization boot and noted a "history of injury." Dr. Alvarado noted that Petitioner was seeing an orthopedic specialist and suggested he continue with exercises to stretch the Achilles tendon. Petitioner was noted to be having some memory issues. (RX 5)

On August 16, 2013 Ellen Peradotto e-mailed Theresa Smith inquiring about a "CF" for an accident date of 2/2/0/12. Ms. Peradotto was informed there was nothing. (RX 2)

Petitioner has continued to treat with Family and Internal Medicine from June of 2013 through May of 2014. During this time no left lower extremity issues were noted. (RX 5)

On October 16, 2014, Petitioner returned to Dr. Aquino. Dr. Aquino noted that Petitioner continued to complain of intermittent pain and discomfort at the posterior aspect of the heel that lasts for several hours. He described the pain as acute and aching in nature, better with rest and altering shoe gear. Aggravating factors were prolonged standing, walking and shoes. Dr. Aquino noted pain on palpation of the posterior heel at the insertion of the Achilles tendon and pain with dorsiflexion of the foot. A bony prominence was palpable on the posterior aspect of the calcaneus with swelling present. X-rays revealed a posterior calcaneal exostosis at the attachment of the Achilles tendon. Petitioner was recommended to continue with immobilization and to utilize the pneumatic cam walker. (PX 4)

A hearing was held before this Arbitrator on July 29, 2014 regarding Respondent's Motion to Consolidate the claims and a motion to continue the hearing noticed up by Petitioner. On July 29, 2014, the parties appeared by agreement to argue Respondent's motions. After extensive discussion and argument, Respondent's Motion to Consolidate and Motion to Continue to obtain a §12 examination were granted over Petitioner's objections. Respondent was instructed to schedule its independent medical examination forthwith. Respondent's Motion to Dismiss the two consolidated claims was discussed and Petitioner presented a written Response to Respondent's Motion to Dismiss. After lengthy discussions, Respondent agreed it had enough information to proceed as counsel now understood the nature of Petitioner's claim and Respondent withdrew its Motion to Dismiss. (See AX 7)

On October 28, 2014, all claims were set for immediate hearing by agreement of counsel. When the case was called for trial, Respondent presented a renewed Motion to Continue and its original Motion to Dismiss. Respondent argued three bases for its Motion to Continue. First, Respondent requested additional time to obtain a §12 examination. Second, Respondent desired to obtain Petitioner's personnel records from Alton Mental Health in preparation for Petitioner's hybrid accident theory. Third, Respondent sought to subpoena the medical records of Dr. Aquino, because Petitioner had recently visited this physician. In response to Respondent's renewed Motion to Dismiss, Petitioner agreed to amend his Applications for Adjustment of Claim in 12-WC-39747 and 12-WC-44647 to allege aggravations of pre-existing conditions "by pushing 500 lb. carts." Petitioner also presented evidence that Respondent had set a §12 examination on September 15, 2014 and unilaterally cancelled the examination. Respondent asserted that it cancelled the examination due to a lack of information from Petitioner's counsel and its fear of Petitioner's mental competence to discuss his claims with the examining physician. Petitioner responded that all pertinent information was exchanged on July 29, 2014 and there was sufficient information to proceed with a §12 examination. Petitioner presented additional evidence that the personnel records had been previously subpoenaed and produced by Respondent in 2012 and were readily available for trial. Over Petitioner's objection, Respondent's Motion to Continue was granted, in part, and Respondent was given a 10-day continuance. The case was set for a trial date certain under §19(b) of the Act on November 7, 2014. (See AX 7)

On November 7, 2014, Petitioner presented two Amended Applications for Adjustment of Claim that had been filed and presented to Respondent prior to the hearing. Claim Number 12-WC-39747 was amended to allege that on August 16, 2012, Petitioner suffered an aggravation of a pre-existing condition to his left foot/ankle, left leg by pushing 500 lb. carts. Claim Number

12-WC-44647 was amended to allege that on February 20, 2012, Petitioner suffered an aggravation of a pre-existing condition to his left foot/ankle while pushing 500 lb. carts.

Respondent then renewed its Motion to Continue for the purposes of setting a §12 examination. Respondent cited as basis its original Motion to Dismiss Petitioner's Applications for Adjustment of Claim alleging that Petitioner's claims were vague and incomplete. It also cited Petitioner's Amended Application in Claim No. 12-WC-39747, which changed the date of alleged accident from September 17, 2010 to August 16, 2012. Respondent requested leave to conduct a §12 examination with Dr. Schmidt on December 4, 2014, and either continue the trial or leave proofs open to obtain the examination. Because Respondent's request was granted on July 29, 2014 and Respondent was ordered to obtain an examination forthwith, Respondent's renewed Motion to Continue was denied.

Petitioner testified that he was employed by Respondent as a stationary engineer and had worked in that capacity for approximately fourteen years prior to his retirement on December 31, 2012. Petitioner provided testimony regarding his accident on August 11, 2010. Petitioner testified that he was called to the Holly building to repair an air conditioner. In his first trip up the back steps of the facility, he took a load of hoses to complete the repair. On his second trip, he ascended the stairs holding two (2) bags of tools. Petitioner testified that the concrete on the stair "caved away" and he hit his shin and "sprung" his ankle. Petitioner testified his foot rolled down, pulled on his leg and he hit the top edge of the step and cut "it" down to the bone. Petitioner pointed to the area of his shin, halfway between his knee and his ankle, and described suffering a laceration. Petitioner was unable to report the injury that day because the incident occurred at the end of his shift, and most of the nurses and his supervisor, Steve Adler, had gone home. He testified that he bandaged his leg himself using a cleaning rag. He also testified that he put peroxide on it when he got back to the engineering building.

The next day, Petitioner reported the injury to the workers' compensation coordinator, Theresa Smith, who directed him to St. Anthony's Health Center for emergency treatment.

Petitioner testified that he took these photographs of the area where he fell in October of 2012, when he sought legal representation for his claims. The photographs demonstrate cracked concrete that appears to have crumbled in various areas. (PX 10)

Petitioner testified regarding his visit to St. Anthony's Health Center. While he remembered the physicians being mostly concerned about his blood pressure, an x-ray was performed of the leg and the wound was cleaned, sterilized, and re-bandaged. On cross-examination, Petitioner testified that he hit the front of his shin and the back of his calf muscle hurt down to his ankle. He also testified that the bony prominence on either side of his foot by the ankle swelled. Petitioner testified that the day after the accident "it" really "puffed up" and he though maybe an infection was setting in. He could not recall if there was any discoloration. He "believed" he told St. Anthony's personnel about his ankle pain and that he believed the hospital performed x-rays of his foot while he was lying down. He though he told personnel he was using peroxide on it and the whole area and ankle was "swelled up pretty much." Petitioner was told to change the bandage, and he recalled discussing soaking and putting ice packs on the swelling.

Petitioner testified that the only time he missed from work after his August 11, 2010 accident was the time necessary treatment at St. Anthony's Health Center and he then promptly returned to work after he finished treatment.

Petitioner then testified that his leg became infected and it took about a month to resolve. He testified he went to Dr. Alvarado and got medication.

Petitioner testified that prior to the August 11, 2010 incident he never suffered any injury or symptoms nor had he undergone any treatment to his left lower extremity. He testified that he played football, track, ran, and was very active with no problems in his feet. Two to three years before 2010, Petitioner recalled once feeling sore calves after running across an open field of plowed ground pursuing a suicidal recipient who was an avid long distance runner trying to elope from the facility. He stated the soreness in his calves resolved after the incident.

Petitioner testified that his left lower extremity was never normal after the accident. He described swelling in his left for which he would clean and soak it. Petitioner testified about a "fellow employee" who would join him for lunch while he soaked his foot.

Petitioner testified that he did not seek any additional medical care and treatment for his left lower extremity until February 20, 2012. However, Petitioner did testify that between the accident date and 2012 he had "access to ultrasound" through a friend and used his equipment to help "move the water out." On cross-examination Petitioner explained that the friend is a second cousin who is also a medical doctor and chiropractor, Dr. Ayres. Petitioner testified he would go to his office located in the basement of his home and undergo ultrasound treatment on his ankles and heel. He began doing that about a year or year and a half after the 2010 accident.

Petitioner testified that various activities at home and on the job would affect his left lower leg and ankle area, such as climbing ladders and stairs, mowing his lawn, walking up a roof, driving, sleeping wrong, or walking on uneven surfaces.

Petitioner testified that he would move food carts and do some ladder climbing and notice his ankle. Prior to 2012 he would push food carts perhaps once a week. However, in late 2011 and early 2012 his duties of pushing 500 # carts increased. While not a part of his regular job duties Petitioner explained he would be called upon to help straighten up tipped carts and push meal carts due to personnel absences and reductions in force. Petitioner testified that as he pushed the carts, especially up ramps, he would "suffer from it" in his foot and get a "quick pain."

Petitioner testified that he went to Dr. Aquino in February of 2012 because he suspected a bone spur. Petitioner testified that Dr. Aquino confirmed that he had a bone spur and a torn achilles tendon. Regarding the reference in Dr. Aquino's February 20, 2012 office visit to his continued use of a pneumatic cam walker which he already had, Petitioner explained that it was his wife's pneumatic cam walker from a previous fracture of her foot and he was able to use it. Petitioner also testified that when Dr. Aquino explained the mechanism of injury to him, he recalled that he had pushed heavy carts that day at work and experienced pain.

Petitioner testified that pushing 500 pound carts of food at mealtime was not a formal job duty that fell under Petitioner's job description. However, due to the retirement of teamster drivers that were not replaced, the facility was short-staffed. There were two remaining drivers in 2012 and, if they were out on a delivery or taking a patient to a medical appointment, Respondent requested Petitioner to fill in and perform this job duty. Petitioner testified that the drivers had his phone number and, when they couldn't make it back to the facility in time to drive and deliver food carts, they would call him and he would fill in as needed. Alton Mental Health is a large facility, and delivery of the food carts was required for recipients to be fed. Petitioner's duties in this respect increased at the end of 2011 and 2012. To deal with his increasing symptoms, he would try home remedies and even used an ultrasound machine his cousin, a retired chiropractor suffering from cancer, kept in his basement to work on the swelling and lump in his foot. Petitioner testified that he was simply trying to speed up his recovery because he didn't intend to pursue a claim.

Petitioner testified that on February 21, 2012 (the day after his visit with Dr. Aquino when they discussed his mechanism of injury) Petitioner informed Steve Adler, his supervisor, about his injury and doctor's appointment. Petitioner testified that Mr. Adler told him not to push carts. Petitioner testified that he continued to do so, however, because food needed to be delivered and no one else was available to help out.

Petitioner testified that he was unable to wear the pneumatic cam walker at work but did wear it when he was not at work and also took the medication as prescribed. Initially, he noted improvement.

Petitioner further testified that over the summer of 2012, more vacancies were occurring at work and some weeks he was required to push food carts for two meals a day. Petitioner estimated that he would push carts in a given week four to five times, and on a hectic week it would require pushing carts for seven different meals. During a less hectic week, Petitioner would push carts two or three times. Petitioner described that there were times when he was asked to volunteer to push carts; other times he was temporarily assigned as a supervisor and it was his responsibility to make sure the job got done. He testified that sometimes the facility was so short staffed that, if he didn't fill in, the job couldn't get done. He testified that he tried to manage himself to where he wouldn't get pain when he pushed a cart, but it was inevitable.

Petitioner testified that he returned to work with the "inner boot"/ankle brace issued by Dr. Aquino in August of 2012. He used the ankle brace inside of his high-top boot. He stated that the device made him feel too confident and he would actually feel his ankle pop while pushing carts. Petitioner recalled feeling a pop in his foot as he pushed a meal cart on the back dock on August 16, 2012. He decided that day to stop assisting with pushing food carts when requested and he told people at work that he wouldn't do it. During this time Steve Adler, his supervisor, retired.

Petitioner testified that in September of 2012 he was requested to get a slip from his doctor regarding his refusal to drive and deliver food carts. This request stemmed from an earlier discussion with Petitioner regarding alleged acts of insubordination. Petitioner testified that he did as requested. Petitioner testified that he was called into a meeting with his union

representative, Floyd Fessler, and Mr. Ellis some time the week before the e-mail was drafted. Petitioner was accused of nine counts of insubordination for failure to drive and deliver food carts and was instructed to obtain a doctor's excuse for the refusal to drive and deliver food carts. Petitioner's Exhibit 8 is Inter-Office Correspondence initially dated September 17, 2012 and signed by Petitioner and Randy Ellis on September 21, 2012.

Petitioner acknowledged that he was suspended in 2012 as a result of an altercation between himself and Mr. Ellis. Petitioner also explained that the discipline memo and meeting in the fall of 2012 dealt with several issues but had nothing to do with cart pushing. However, he added that in a meeting around that time when he was being accused of being insubordinate his foot problem came up. According to Petitioner, everyone knew he had a food problem. A "guy in Springfield" finally said "let's get a doctor's excuse." Petitioner agreed that after September 17, 2012 he did not push any more food carts.

Petitioner testified that until job action was taken against him in September of 2012, he had not sought any legal advice with regard to his work injury. He believed that the climate at work changed after he informed Respondent of his injury and work restrictions. Petitioner sought the advice of an attorney in October of 2012 at the suggestion of his wife.

Petitioner also testified that he took the photographs in October of 2012 (PX 9, 10) when he retained counsel for these claims. Petitioner testified that the current appearance of his ankle is different than what is depicted in Petitioner's Exhibit 9 and that the swelling has improved.

Petitioner testified that he has been unable to be seen by an orthopedic specialist because of health insurance and workers' compensation issues. Petitioner testified that he would like to see an orthopedic specialist, as he continues suffer symptoms and have need for an immobilization device. The Arbitrator notes that Petitioner was wearing a pneumatic cam walker throughout his Arbitration. Petitioner testified to continuing to alternate between the pneumatic cam walker and the ankle support, at times wearing one, both, or neither. Sometimes he goes without it for a month. He continues to have pain and throbbing in his left foot and he is not "totally healing." He described a big lump to the right of the tendon in the back of the ankle toward the inside of the foot that frequently changes in size with activity. To control the symptoms, he uses one foot at a time, limits his activity, and immobilizes his foot. Petitioner no longer drives long distances or mows the hilly area of his lawn, but hires someone to do it, due to the condition of his foot. Petitioner testified that he still experiences a "phantom feeling" of a cut on his shin.

Petitioner testified that he elected to pursue FMLA leaves of absence in September and November of 2012 due to the changing work situation, various allegations against him, and the condition of his foot.

Petitioner testified that Petitioner's Exhibits 12 and 13 are Petitioner's notes that he made to document his attempts to formally report his 2012 injuries to Respondent. Petitioner testified that the Workers' Compensation Coordinator, Theresa Smith, would not accept his injury report, so he contacted CMS representatives in Springfield, Linda Mills and Dave Kinworth, who instructed him to put his current treatment under the claim number assigned to his August 11,

2010 injury. He testified that he told the representatives in Springfield that he felt that his current problems cascaded from the August 11, 2010 injury. He also explained to them that it was reoccurring. The numbers written by Petitioner in his notes on Petitioner's Exhibit 12 coincide with Respondent's file number for Petitioner's August 11, 2010 injury documented in Petitioner's Exhibit 6. Petitioner wrote on these forms that he was attempting to report an injury for "repetitive use when pushing food carts on Achilles Tendon Rupture." Petitioner testified that he tried to submit these forms to Theresa Smith, but she was hesitant to take them, and that was why he contacted representatives in Springfield. On cross-examination, Petitioner could not recall the dates when these notes were taken, when he attempted to make a report to Respondent, or when Respondent allegedly refused to make a report.

Petitioner's Exhibit 14 purports to be one method by which Petitioner received work assignments -- ie., post-it notes. Petitioner testified PX 14 was a post-it note left on a door to give him work assignments. Petitioner's Exhibit 15 documents Petitioner's request for time off and response that Petitioner would be required to be present at a disciplinary hearing. Petitioner was charged with various disciplinary infractions in October of 2012. E-mail correspondence documenting the charges is attached.

On cross-examination Petitioner could not recall the significance of various dates he was asked about -- for ex., 2/2/0/12 and 8/16/12. On redirect examination Petitioner acknowledged that he has occasionally had trouble with his memory and that his memory issue(s) may have had an impact on his testimony but he was trying to be accurate.

Petitioner's earnings records are found in PX 5 and 6. Petitioner testified he could not recall exactly what he was earning during the times in question but recalled that he thought he broke a hundred thousand a few times. He testified that overtime was mandatory.

At the conclusion of Petitioner's testimony, the case was continued until November 12, 2014.

When the hearing reconvened, Randy Ellis was called to testify on behalf of Respondent. Mr. Ellis testified that in June of 2011, there were five drivers that would deliver food carts. One driver retired on June 30, 2011, another retired on December 29, 2011, and a third retired on May 31, 2012. Mr. Ellis testified that in January of 2012, he pushed carts on average 3-5 times per month. After May of 2012, Mr. Ellis testified that he pushed carts on average of 10-15 times per month. Mr. Ellis testified that sometimes it was less, and sometimes it was more.

Mr. Ellis testified that September 17, 2012 was the first date he became aware that Petitioner had refused to drive and deliver food carts. On cross-examination, Mr. Ellis reviewed his September 17, 2012 e-mail and admitted that, since that day was a Monday and neither he nor Petitioner worked weekends, Petitioner's refusal to drive and deliver food carts would have been discussed at a meeting the week before the e-mail was drafted.

Mr. Ellis testified that in June of 2011, there were five drivers that would deliver food carts. One driver retired on June 30, 2011, another retired on December 29, 2011, and a third retired on May 31, 2012. Mr. Ellis testified that in January of 2012, he pushed carts on average 3-5 times per

month. After May of 2012, Mr. Ellis testified that he pushed carts on average of 10-15 times per month. Mr. Ellis testified that sometimes it was less, and sometimes it was more.

Mr. Ellis admitted to receiving both the September 17, 2012 and September 20, 2012 restriction slips from Petitioner. Petitioner's Exhibit 8 is Inter-Office Correspondence initially dated September 17, 2012 and signed by Petitioner and Randy Ellis on September 21, 2012. This correspondence appears to be a settlement of some disciplinary charges involving Petitioner. He further testified that after Mr. Adler's retirement, Petitioner was chosen to receive the temporary assignment of assistant chief engineer; however, that did not come to fruition as Petitioner was 30 minutes late in responding to a radio call for a meeting, which resulted in Mr. Ellis being promoted to the position instead.

Mr. Ellis conceded on cross-examination that there was a meeting the week before September 17, 2012, although he could not recall the date, where Petitioner was charged with 9 counts of insubordination and one of the problems discussed was the refusal to drive and deliver food trucks. Petitioner could refuse to drive and deliver food carts because it was not a job requirement, but after this meeting, Mr. Ellis stated that a doctor's excuse was required by Respondent. He acknowledged that Petitioner's union representative would have been present due to an allegation of misconduct. Petitioner provided that doctor's excuse and Randy Ellis testified that, during the meeting the week before September 17, 2012, there was no doubt in his mind that Petitioner was refusing to drive and deliver food carts due to a medical condition for which he was seeking a doctor's care. He also admitted to being notified the week before September 17, 2012 that Petitioner suffered in increase in pain when he would push and deliver food carts.

Mr. Ellis admitted on cross-examination that he would not be aware of every time Petitioner pushed a food cart, nor would Petitioner necessarily be aware when he was pushing a food cart. He also testified that he did not work the same shift as Petitioner until June or July of 2012. Petitioner was the first engineer on duty, from 7:00 a.m. to 3:00 p.m., and Mr. Ellis worked from 2:00 p.m. to 10:00 p.m.

Mr. Ellis also testified that, if he was injured at work, the appropriate way to report the injury would be to either tell a supervisor or to fill out either a long or a short form of injury, and that he would either do one or the other.

Mr. Ellis admitted that Petitioner was not disciplined after providing a doctors excuse on September 20, 2012, but was required to sign a memorandum of understanding. Respondent produced no record of these issues, discipline, or meetings in Petitioner's personnel file that was produced pursuant to Petitioner's subpoena. Mr. Ellis testified that he believed Petitioner retired because of his failure to be promoted. Mr. Ellis did not believe that Petitioner had been subjected to any further disciplinary allegations after reporting his foot injury; however, Petitioner's Exhibit 15 demonstrates that Petitioner was subjected to additional allegations and potential discipline in October of 2012.

Valerie Hall testified for Respondent. She became the workers' compensation coordinator for Respondent on February 1, 2013. She testified that she was asked to find documents related to

Petitioner's 2012 claims and could not find any. She also testified that she produced Respondent's Exhibit 10 at the request of Respondent. Prior to February 1, 2013, Theresa Smith was the workers' compensation coordinator. Ms. Hall acknowledged that Theresa Smith or Steve Adler would have been the appropriate persons for Petitioner to report an injury.

Prior to being a workers' compensation coordinator, Ms. Hall worked as an office associate, Store Clerk I and Store Clerk III. In her job duties, she became familiar with Petitioner and monitored radio traffic. There were areas in the facility where radio signal was unavailable and that it was common for radio calls to be missed. She acknowledged that Petitioner's job duties varied daily and that he did assist in pushing/pulling and delivering heavy carts. At times, she agreed that there were only two drivers available to deliver and push foot carts and Petitioner would fill in performing that duty. He would push them down halls, on trucks, off trucks, up ramps, down ramps, through double doors, indoors, outdoors, in bad weather, and in good weather. She described the carts as heavy, weighing 400-500 lbs., when full. The wheels required maintenance because they did not work well and made the carts more difficult to push. When asked about Petitioner's Exhibit 13, where Petitioner reports that he received first aid in the form of ice packs for "repetitive use when pushing food carts on Achilles tendon rupture," Valerie Hall stated that the ice packs would have been received from the nurse on the unit at the facility. Valerie Hall admitted that, although she is a workers' compensation coordinator, she did not necessarily fill out a formal form each time she was injured on the job.

In rebuttal, Petitioner testified that he retired because the retirement economics did not support his continuing to work, his foot continued to worsen, and that he felt he was being discouraged from continuing employment by management. He testified that he knew of other employees who had been injured, including pulling rotator cuffs, as a result of pushing heavy carts.

Respondent submitted 10 exhibits. Respondent's Group Exhibit 1 documents Petitioner's incident of August 11, 2010. Respondent's Exhibit 2 documents Petitioner's prior Workers' Compensation Settlement. This settlement was for a scar Petitioner sustained after a chemical burn to his right hand while cleaning compressors. Petitioner testified that he filed this claim at the advice of his attorney after consulting her in October of 2012 regarding the instant claims. Respondent's Exhibit 3 documents a variety of prior work injuries reported by Petitioner. Respondent's print-out demonstrates that Respondent closed its case within 4 days to 4 months of each injury report. Petitioner never filed a formal workers' compensation claim until November 2012, after consulting an attorney. Respondent's Exhibit 3 titled "No Incident Reports – 2012 Claims" contains a fax from Theresa Smith to "Jason" on 18 January 2013 stating: "It looks like I gave you the wrong date of services. Attached is the information from claim number 0761207 for date 08/02/10. Should you have any questions feel free to contact me at the number listed above."

The Arbitrator concludes:

At the outset the Arbitrator notes Petitioner's acknowledged (and medically documented) issue with his memory. As such, the Arbitrator has tried to be sensitive to it as she has weighed and

considered all of the evidence and testimony and the circumstances/activity going on throughout the two days of hearings. While he may not have recalled during cross-examination the significance of certain dates central to his claim, the Arbitrator has not put much weight to that. However, Petitioner was wrong/confused in his recollection of certain things. For example, while he testified to being diagnosed by Dr. Aquino with a torn achilles tendon, his medical records document he was diagnosed with tendinitis and was "at risk" for a rupture. A torn achilles tendon was never diagnosed. If Petitioner could be confused regarding this point, he might be confused on other points (such as conversations with people at the hospital after the accident) Thus, while the Arbitrator believes Petitioner was doing his very best to be truthful and accurate, the objective evidence has to carry a great deal of weight in this instance.

1. **Case # 12 WC 39746 (D/A: 8.11.10)**

ISSUE (C) Did an accident occur on August 11, 2010 that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner sustained an accident on August 11, 2010 that arose out of and in the course of Petitioner's employment with Respondent. Petitioner's job required him to ascend steps in order to repair the air conditioner unit. Petitioner fell in the course and scope of his employment when ascending a stairwell while carrying two bags of tools. The objective evidence is that he fell forward sustaining a laceration wound to his left shin, below the knee.

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

Petitioner's current condition of ill-being in his left foot and ankle is not causally related to the accident of August 11, 2010. This conclusion is based upon gaps in medical treatment, the absence of a causation opinion, and the mechanism of injury itself.

While Petitioner testified to believing he injured his ankle on the date of the accident, there is no objective evidence of any injury to Petitioner's ankle at the time of his accident. Petitioner didn't claim one when he reported his injury. Medical records from St. Anthony's Health Center, including pain drawings, fail to indicate an ankle or foot injury. Petitioner had some treatment with his family doctor in August of 2010 but, again, it was for cellulitis to his left shin. There is no mention of foot, heel, or ankle concerns. Petitioner testified about a fellow employee who would occasionally eat lunch with him and allegedly witnessed the swelling and soaking of his ankle/foot. However, Petitioner didn't identify any employee or have any witnesses testify in support thereof. Petitioner also spoke about his home remedies, including the use of Dr. Ayers' equipment; however, thee is not corroboration for this testimony.

After the initial treatment for his shin in August of 2010, Petitioner underwent no further treatment to his left lower extremity (for which we have objective evidence) until February 20, 2012, over 1 1/2 years after the 2010 accident. When seen by Dr. Aquino in February of 2012, Petitioner complained of left heel pain which had started several years

earlier; however, the records pre-dating this visit don't indicate Petitioner had heel pain beginning on August 11, 2010. Additionally, Petitioner alleged his heel pain was being aggravated by his "new duties" of pushing 500 lb. carts.

In order to establish ongoing causation Petitioner relies upon his testimony that he believed he "sprung" his ankle at the time of the accident and he believed he told hospital personnel about his ankle pain on August 12, 2010, that he underwent x-rays for his foot, that he was instructed to change his bandage for which he recalled soaking and icing for swelling, and that he tried "home remedies" to treat his problem. The medical records, however, do not corroborate his testimony. Even if one gives Petitioner the benefit of the doubt concerning this testimony at the hospital, his exam on August 12, 2010 was negative and when Petitioner testified to soaks and ice for swelling, he didn't elaborate as to where the swelling was located.

Petitioner testified that his leg became infected and it took about a month to resolve. This was treated with Dr. Alvarado in August of 2010; however, there is no mention of the accident and no mention of heel or ankle pain in the doctor's records. Petitioner submitted the bill through his group health insurance.

Petitioner failed to produce any medical evidence in the form of expert testimony to establish causation. None of the doctors were deposed. A chain of events analysis won't work due to gaps in treatment combined with other alleged causes (ie. cart pushing). Additionally, there needs to be expert testimony explaining how an injury to the front of Petitioner's shin could result in his ankle and heel problems when objective evidence doesn't show he injured either during the accident. There is also the history found in the December 11, 2012 office visit with Dr. Alvardo wherein Petitioner conveyed to the doctor's nurse practitioner the insidious onset of musculoskeletal pain in his ankle region two months earlier. While there are histories contained in various medical records expressing Petitioner's belief that his ankle and heel problems began with his 2010 injury, there are no medical opinions from the doctors based upon a complete understanding of Petitioner's injury and treatment contained in those notes or produced elsewhere. None of the doctors were deposed.

Based upon the foregoing, the Arbitrator concludes that Petitioner failed to prove a causal connection between his current condition of ill-being in his left ankle/heel and his accident of August 11, 2010.

ISSUE (G) What were Petitioner's earnings?

Petitioner failed to prove his alleged average weekly wage and earnings. His testimony regarding his earnings was too vague. Accordingly, the Arbitrator concludes that Petitioner's earnings for the year preceding his accident were $92,918.40 and his average weekly wage was $1,191.26. (See AX 1)

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?

Having determined that Petitioner sustained an accident on August 11, 2010 Petitioner is awarded medical bills in the amount of $300.00 for emergency services rendered to him on August 12, 2010 at St. Anthony's Health Center. Respondent is entitled to a credit towards this bill for any payments made by its group medical plan for which credit is allowed under Section 8(j) of the Act. The remaining bills found in PX 1 are denied consistent with the Arbitrator's causation determination above.

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

Given the Arbitrator's causation determination above, Petitioner's claim for prospective medical care is denied.

2. **Case # 12 WC 39747 (D/A: 8.16.12)**

ISSUE (C) Did an accident occur on August 16, 2012 that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner failed to prove he sustained an accident (specific or repetitive in nature) on August 16, 2012. While Petitioner testified that he "recalled" feeling a pop in his foot as he pushed a meal cart on the back dock on August 16, 2012, his testimony was just that -- a recollection or belief. There is no corroborating evidence -- no injury report or mention of it in any medical records. Petitioner could not testify with specificity as to whom, if anyone, he gave notice of that alleged accident to. At most, he testified that he "explained" to other employees that his medical condition was the reason he could no longer assist in performing this duty.

Additionally, Petitioner failed to prove how a repetitive trauma injury to his left foot, ankle, and heel manifested itself on August 16, 2012 or arose out of his employment with Respondent.

Petitioner's claim for compensation is denied and no benefits are awarded.

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

Even assuming, arguendo, that Petitioner sustained an accident on August 16, 2012 he failed to prove he provided notice to Respondent as required by the Act.

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

Even assuming, arguendo, that Petitioner sustained an accident on August 16, 2012 he failed to prove his current condition of ill-being in his left heel/ankle is causally related to his August 16, 2012 accident.

ISSUE (G) What were Petitioner's earnings?

Consistent with her determinations as to accident, notice and causal connection above, this issue is rendered 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?

Consistent with her determinations as to accident, notice and causal connection above, this issue is rendered moot.

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

Consistent with her determinations as to accident, notice and causal connection above, this issue is rendered moot.

3. Case #12 WC 44647 (D/A: 2.20.12)

ISSUE (C) Did an accident occur on February 20, 2012 that arose out of and in the course of Petitioner's employment with Respondent?

Petitioner failed to prove he sustained an accident on February 20, 2012 that arose out of and in the course of his employment with Respondent.

First, Petitioner did not sustain a specific trauma/accident on February 20, 2012. He did not testify to a specific accident nor did he report a specific accident to any medical providers. At most February 20, 2012 is the date on which Petitioner, as reflected in Dr. Aquino's records, may have seen a relationship/correlation between his heel pain and his job duties of pushing food carts. However, Petitioner failed to prove that his injury arose out of his employment. Petitioner offered no expert opinion on the issue. Both Dr. Alvarado's and Dr. Aquino's records are void of any details about Petitioner's work activities, except for a general reference to pushing 500 lb. carts. There is no description of the carts, what condition they were in, when and where they were pushed, how they were pushed, how many times they were pushed, or how long they were pushed. Furthermore, Petitioner testified that it was not only the pushing of carts at work that bothered him but also a variety of other activities -- walking, standing, and going up and down stairs.

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

Based upon her liability determination this issue is moot.

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

Petitioner failed to prove that his current condition of ill-being is causally connected to his alleged accident of February 20, 2012. In support thereof the Arbitrator incorporated her analysis as set forth in 3(C) above (accident).

ISSUE (G) What were Petitioner's earnings?

Based upon her liability determination this issue is 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?

Based upon her liability determination this issue is moot.

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

Based upon her liability determination prospective medical care is denied.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF MCCLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael J. Marsh,
Petitioner,

vs.

NO: 10WC 30711

Tzank and Hermann Stroink
and State of Illinois Treasurer
as Ex-Officio Custodian of the
Injured Workers' Benefit Fund,
Respondent,

15IWCC0615

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 17, 2014, is hereby affirmed and adopted.

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

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

15IWCC0615

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Illinois Attorney General represented the Treasurer. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

DATED: AUG 1 1 2015
o080415
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARSH, MICHAEL J
Employee/Petitioner

Case# **10WC030711**

TZANK AND HERMANN STROINK AND STATE OF ILLINOIS TREASURER AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0615

On 11/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
DIRK A MAY
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

0740 THIELEN FOLEY & MIRDO LLC
JOSEPH W FOLEY
207 W JEFFERSON ST SUITE 600
BLOOMINGTON, IL 61701

5116 ASSISTANT ATTORNEY GENERAL
GABIREL CASEY
500 S SECOND ST
SPRINGFIELD, IL 62706

STATE OF ILLINOIS)
)SS.
COUNTY OF McLean)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael J. Marsh
Employee/Petitioner

v.

Tzank and Hermann Stroink and State of Illinois Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **10** WC **030711**

Consolidated cases: _____

15IWCC0615

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Stephen Mathis**, Arbitrator of the Commission, in the city of **Bloomington**, on **November 14, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0615

FINDINGS

On **July 28, 2009**, an employee-employer relationship ***did not*** exist between Petitioner and Respondent.

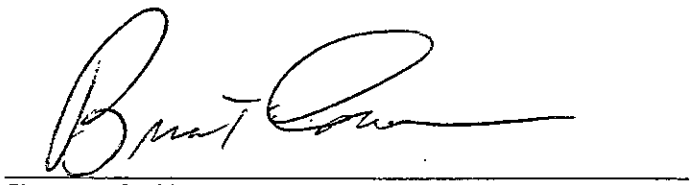
On that date, Petitioner was **45** years of age, ***married*** with **2** dependent children.

ORDER

Arbitrator Brian Cronin has found that Petitioner has failed to prove that on July 28, 2009, he was an employee of Respondent. Therefore, he denies compensation. All other issues are moot.

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

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



Signature of Arbitrator

November 14, 2014
Date

ICArbDec p. 2

NOV 17 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
ATTACHMENT

Michael Marsh
Employee/Petitioner

v. Case # **10** WC **30711**

Tzank and Hermann Stroink and State of Illinois Treasurer as Ex-Officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

15IWCC0615

On November 14, 2013, Arbitrator Stephen Mathis heard this case. In early 2014, Arbitrator Mathis was appointed to the position of Commissioner, Illinois Workers' Compensation Commission. Some time thereafter, the Chairman's Office re-assigned the unwritten decisions of former Arbitrator Mathis to various IWCC Arbitrators. The above-captioned case was assigned to Arbitrator Brian Cronin for the rendering of a decision.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

In support of his decision with regard to issue (B) "Was there an employee-employer relationship?", the Arbitrator makes the following findings of fact and conclusions of law:

The threshold issue in this case is whether Mr. Marsh, on June 28, 2009, was an independent contractor or an employee of the Respondent.

The Illinois Supreme Court has identified several factors that help determine when a person is an employee, namely: (1) whether the employer may control the manner in which the person performs the work; (2) whether the employer dictates the person's schedule; (3) whether the employer pays the person hourly; (4) whether the employer withholds income and social security taxes from the person's compensation; (5) whether the employer may discharge the person at will; and (6) whether the employer supplies the person with materials and equipment. Roberson v. Indus. Comm'n, 225 Ill. 2d at 175 (2007).

Another relevant factor is whether the employer's general business encompasses the person's work. Roberson, 225 Ill. 2d at 175.

The label that the parties place on their relationship is another relevant factor, although it is a factor of "lesser weight." Ware v. Indus. Comm'n, 318 Ill. App. 3d at 1122 (1st Dist. 2000).

Whether an employment relationship exists rests on the totality of the circumstances, and no single factor is determinative. Roberson, 225 Ill. 2d at 175; see also Earley v. Indus. Comm'n, 197 Ill. App. 3d at 314-

315 (4th Dist. 1990) However, the right to control the manner of the work is the most important consideration. Roberson, 225 Ill. 2d at 175; Ware, 318 Ill. App. 3d at 1122; Peesel v. Indus. Comm'n, 224 Ill. App. 3d at 713 (1st Dist. 1992).

On July 28, 2009, as a result of an explosion in a well, Michael Marsh suffered devastating injuries. He lost his right eye, which has been replaced with a right orbital implement. He underwent extensive surgery for his nasal and skull injuries. He also sustained injuries to his cervical spine. Mr. Marsh complains of skull pain, facial pain, sinus problems and chronic neck pain.

Petitioner testified that he was employed by Respondent to perform general maintenance, upkeep and repairs on two properties: the "White house" and the "Red house". He claimed that there were four other "workers" for Respondent: his brother, Kevin Marsh, who performed mechanical work on the Respondent's vehicles, Josh, last name unknown, Hermann Stroink and Brad Marsh, Petitioner's nephew who handled the paperwork.

Brad Marsh, who was called by Petitioner, testified that he was the Respondent's "property manager" for the properties and that Respondent had between five and ten employees.

The evidence shows that Hermann Stroink lived in the "White house" and was on the two properties almost every day.

Other than himself, Hermann Stroink denied ever having any employees for Tzank, Inc., or considering that anyone was an employee of Tzank, Inc. At the time of the incident, Hermann Stroink testified, he was retired. He further testified that Kevin and Michael Marsh talked him into incorporating Tzank, Inc., so that he could shield himself from liability. Mr. Stroink testified that he purchased "the White house" in 1980, and kept it as his residence. Mr. Stroink testified that in 2008, he purchased, in his own name, the "Red house", which is a farmstead that was built in 1835. He planned to convert this property into a bed & breakfast or a hunting lodge.

Hermann Stroink requested that Petitioner, Kevin Marsh and Brad Marsh complete tasks at both properties in question. Petitioner would also come to Mr. Stroink with suggestions for projects and recommendations that he perform certain work for the "Red house." Petitioner performed such tasks as yard work, replacement of a water heater, plumbing, carpentry and kitchen remodeling. Mr. Stroink testified that he used other contractors at the "Red house", such as an electrician and carpet installer. Petitioner and Mr. Stroink offered testimony that they would occasionally meet to discuss the nature of certain projects that Stroink envisioned, or that Petitioner would complete drawings and designs for projects that Stroink would look over and would agree that Petitioner could undertake.

The Arbitrator concludes that the assignment of tasks and the discussion of projected results are present in both employment relationships and independent contractor dealings and are not determinative as to whether or not an employee-employer relationship existed between Petitioner and Respondent.

The Arbitrator further concludes that Respondent employer's general business was that of real estate investment. Moreover, the Arbitrator concludes that Michael Marsh's resume (Rx.1) indicates that he and Land/Mar are in the business of evaluating and renovating property, which would suggest an independent contractor relationship.

The Arbitrator's understanding is that the "right to control" involves more than just the assignment of tasks. Mr. Stroink testified that he learned construction "off and on", but that it was just a hobby. When he was in college, he did construction work on an apartment house. However, in the last 20 to 30 years, he only did "hobby work." At ISU, he took courses in "ag mechanics, ag electronics." Mr. Stroink never took any courses in carpentry. While Brad Marsh testified that Mr. Stroink would give Petitioner directions on how to do the work and what to do and supervised the work on a daily basis, Petitioner and Mr. Stroink both testified that Stroink would not instruct

Petitioner on how to do a task or how to use certain tools. Although Mr. Stroink testified that he may be present at the "Red house" and may assist with some of the work, such work consisted of holding a board for Petitioner, nailing an item or observing the progress of a task. There was no testimony to indicate that Mr. Stroink ever controlled the details of the work or task, complained about how or when a task was completed or recommended changes in how a task is to be carried out. Mr. Stroink testified that "[m]ost of the time they would put forth what was to be done and I would just sign off on it or agree to it verbally, yes."

Moreover, there is no evidence to indicate that Hermann Stroink requested that Petitioner perform the very task that he was purportedly undertaking on July 28, 2009, i.e., hooking a compressor to the water ejector for a well on the "Red House" property.

On cross-examination of Petitioner, the following exchange took place:

Q: So as you are working on this abandoned well that day Hermann wasn't standing there directing your work, right?

A: No, that was one of those tasks he assigned earlier.

On direct examination of Hermann Stroink, the following exchange took place:

Q: Did you ever direct Mike Marsh or Kevin Marsh to work on any well prior to July 28, 2009 or on the day of July 28, 2009?

A: No, not directly. That was more of an experimental thing that they were playing with.

On cross-examination of Hermann Stroink, the following exchange took place:

Q: Now, you worked on the well in question at the red house with Michael Marsh before July 28 of 2009, didn't you?

A: Yes, we put a dip tube down in there. Basically a black tube just to see how deep it went because I was thinking of buying a pump for it.

. . . . . .

Q: You knew Michael had worked on that particular well before?

A: No, he didn't work on it. I mean he, that was that one time he designed the piece of equipment that blew up.

Based on a conversation that he had with Kevin Marsh, Brad Marsh testified that Hermann asked Michael Marsh to do some work on the well. After carefully reviewing his testimony, the Arbitrator finds that Brad Marsh's testimony is not persuasive.

Petitioner testified that his brother, Kevin Marsh was present at the time of the explosion. Despite the fact that Petitioner called Brad Marsh, nephew of Petitioner and son of Kevin Marsh, to testify at the Arbitration hearing, Petitioner did not call Kevin Marsh, an occurrence witness, to testify.

The Arbitrator finds that Petitioner would undertake his assigned tasks, such as the kitchen-remodeling project, without further direction from Mr. Stroink. Therefore, the Arbitrator concludes that Hermann Stroink did not control the manner in which Michael Marsh performed his work.

Petitioner testified that the minimum number of hours per week that he had agreed to was 32, at a rate of $11.25 or $11.26 per hour for the sum of $400.00 per week. Petitioner testified that he worked for Respondent 4-5 days per week and that if he had to take off from work, he would write it in the ledger book. Petitioner further testified that he entered all his hours in such ledger book. Hermann Stroink testified that his agreement with Petitioner "was never an hourly thing" but that he and Petitioner "kind of worked it out a little that he would still be making the same amount of money but working as a private contractor." Mr. Stroink further testified that he gave Petitioner "free reign" with regard to the hours worked on the properties. Mr. Stroink never restricted Petitioner from taking any other jobs. In fact, Petitioner testified that he took 2-3 days off work to build a ramp for his mother after she broke her transverse process.

The Arbitrator concludes that Respondent did not dictate Petitioner's work schedule or his ability to engage in outside work, which would be more supportive of an independent contractor relationship.

With regard to the method of payment factor, there was no evidence that regular payments were made to Petitioner by Respondent. In fact, there is no evidence that any payments were made directly to him, rather, that the payments were made to Petitioner's wife, Diane Landry. With the exception of one check for $800.00, which is dated 6/27/09, these payments do not reflect claimed wages of $400.00/week or $800.00 bi-weekly. (Rx.3) The remainder of the checks paid to Diane Landry were odd amounts and did not include checks for any time period before April 21, 2009, despite Petitioner's claims that he had been employed by Respondent since January 1, 2009. Petitioner failed to submit any evidence of wages or income payments, such as check stubs, bank statements, W-2s, 1099s or income tax returns. Testimony established that no taxes were withheld by Respondent, no social security deductions were taken out and regular payments were not made. Rather, it appears that certain payments were made with the completion of tasks. There was simply no evidence to establish that Petitioner worked 32 hours per week (for $400 per week) from January 1, 2009 through the date of accident as claimed by Petitioner. Petitioner testified that the ledger book, in which he recorded his hours, disappeared after July 28, 2009.

The Arbitrator concludes that the method of payment is more supportive of an independent contractor relationship.

No employment agreement or written contract exists. There is no documentary evidence that details Petitioner's work duties or lists the tasks to be performed. Similarly, no exhibits or testimony was presented to establish that Petitioner would be terminated or discharged if work was not performed or if tasks were not completed in a timely manner.

The evidence indicates that Petitioner possessed the skills necessary to complete each task or project requested of him. He scoffed at the notion that Mr. Stroink would need to instruct him as to how to install a cabinet or lay kitchen flooring. According to Mr. Stroink, Petitioner was talented and skilled; he would allow Michael Marsh to use his "creative talents to finish the job."

Hermann Stroink testified that Petitioner used many of Stroink's tools that were on hand at the subject properties. However, Petitioner also used a number of his own tools to perform the tasks at the properties. With regard to the materials, the evidence indicates that Petitioner had Hermann Stroink purchase gift cards from Menard's and Lowe's. Petitioner would then use such cards to purchase materials and would record the balance on each card. Petitioner also sold Hermann Stroink some materials that he had retained from outside projects. Mr. Stroink testified that Petitioner bought materials and brought other some from earlier outside projects.

The Arbitrator concludes that Petitioner's use of his own tools as well as Respondent's tools is present in both employment relationships and independent contractor dealings and not determinative as to whether or not an employee-employer relationship existed between Petitioner and Respondent.

Petitioner procured materials with a gift cards that Hermann Stroink purchased. Petitioner also provided materials that he sold to Hermann Stroink. This would also be a neutral factor and not determinative as to whether or not an employee-employer relationship existed between Petitioner and Respondent.

Petitioner submitted hundreds of pages of medical records (Px.1-9), including medical billings (Px.10) relative to the treatment received on and after the July 28, 2009. Petitioner testified that he had informed his medical care providers that his employer was Respondent. Yet, the first and only documented mention of Respondent as being the employer of Petitioner was the report prepared by the Petitioner's examining physician, Dr. Paul Nord. (Px.1) In fact, no other document names Tzank or Mr. Stroink and the medical records from OSF St. Joseph Medical Center relating to Petitioner's emergent care immediately following the accident reflect that Petitioner was "Self-employed" and his health insurance was Blue Cross/Blue Shield, his wife's insurance carrier. (Rx.2) Furthermore, in Dr. Jack Capodice's medical records, Petitioner completed a Patient Information form wherein he listed "Self" as employer and directed the billings to be sent to BC/BS (BlueCross/BlueShield). Lastly, all of the medical billings were addressed to Petitioner at his home address and not to Respondent. (Px.10)

The Arbitrator finds it significant that the documentary evidence shows, with the exception of Dr. Nord's report, that Petitioner considered himself to be self-employed rather than an employee of Hermann Stroink or Tzank, Inc.

The Arbitrator questions Petitioner's credibility. He testified that in the four years since the July 28, 2009 explosion, he never once asked his brother Kevin, who was an occurrence witness, what had happened that day. Petitioner testified that he did not know if Kevin Marsh had the same employment status that he (Petitioner) had. Furthermore, Petitioner denied that he told the staff at St. Joseph Hospital that he was self-employed and testified that he specifically told them he worked for Tzank Corporation. He also testified that he told Dr. Capodice that he was employed by Tzank, although those records also reflect that Petitioner was self-employed.

The Arbitrator questions Hermann Stroink's testimony that he did not direct Michael Marsh to work on the well on the "Red house" property. Some time before July 28, 2009, Hermann Stroink and Michael Marsh worked together to put a dip tube into the very well in which the explosion occurred. Hermann knew that Michael and Kevin Marsh were conducting "an experimental thing" with the well. Moreover, the Arbitrator questions Mr. Stroink's testimony that, at the time of the explosion, he did not have a good understanding of how wells work. Mr. Sroink is a retired biomechanical engineer.

Notwithstanding, the Arbitrator finds that there is no evidence to indicate that Hermann Stroink requested that Petitioner perform the very task that he was purportedly undertaking on July 28, 2009, i.e., hooking a compressor to the water ejector for a well on the "Red House" property.

Based on the foregoing, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that an employee-employer relationship existed between himself and the Respondent on July 28, 2009. Therefore, the Arbitrator denies compensation. All other issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ARMANDO AVILA,

Petitioner,

vs. NO: 08 WC 1292

LIFE FITNESS,

Respondent,

15IWCC0616

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, vocational rehabilitation, nature and extent, and penalties/fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Although the Commission agrees that Petitioner's condition of ill-being was no longer causally related to his work injury after January 28, 2009, we find that Petitioner is entitled to permanent partial disability benefits related to the cervical and lumbar sprains he sustained on December 8, 2007. We therefore award a total of 12.5 weeks under §8(d)2 of the Act for the combination of cervical and lumbar sprains, representing 2.5% of the person as a whole.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $433.33 per week for a period of 2 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $390.00 per week for a period of 12.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 2.5% of the person as a whole.

15IWCC0616

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $5,800.00. 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.

DATED: AUG 1 1 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 7/15/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

AVILA, ARMANDO
Employee/Petitioner

Case# **08WC001292**

LIFE FITNESS
Employer/Respondent

15IWCC0616

On 6/6/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2902 LAW OFFICES OF PETER G LEKAS
5367 W DEVON AVE
CHICAGO, IL 60606

1832 ALHOLM MONAHAN KLAUKE ET AL
STACEY E HILL
221 N LASALLE ST SUITE 450
CHICAGO, IL 60601

15IWCC0616

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Armando Avila
Employee/Petitioner

v.

Life Fitness
Employer/Respondent

Case # 08 WC 1292

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 **Steffen**, Arbitrator of the Commission, in the city of **Chicago**, on **March 5, 2014 and March 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. [ ] Was there an employee-employer relationship?
C. [ ] Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. [ ] What was the date of the accident?
E. [ ] Was timely notice of the accident given to Respondent?
F. [x] Is Petitioner's current condition of ill-being causally related to the injury?
G. [ ] What were Petitioner's earnings?
H. [ ] What was Petitioner's age at the time of the accident?
I. [ ] What was Petitioner's marital status at the time of the accident?
J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. [x] What temporary benefits are in dispute?
   [ ] TPD [ ] Maintenance [x] TTD
L. [x] What is the nature and extent of the injury?
M. [x] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Vocational Rehabilitation and §8(a)(3)**

FINDINGS

On December 8, 2007, 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 $33,800.00; the average weekly wage was $650.00.

On the date of accident, Petitioner was 55 years of age, *married* with 0 dependent children.

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

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

Respondent shall be given a credit of $0 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

Petitioner's condition of ill being at the time of trial was not causally related to the accident.

Respondent shall pay Petitioner temporary total disability benefits of $433.33/week for 2 weeks, commencing December 11, 2007 through December 25, 2007, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $23,351.00 for medical benefits that have been paid.

Respondent is liable for any outstanding medical bills relating to Petitioner's treatment up until the date of February 23, 2009

Respondent shall pay Petitioner permanent partial disability benefits of $390.00/week for 0 weeks, because the injuries sustained caused the 0% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

Petitioner is not eligible for vocational rehabilitation as he did not attempt to find a job after his employment with Respondent ended.

Respondent's conduct was neither unreasonable nor vexatious and Petitioner is not entitled to penalties pursuant to sections 19(k) and 19(l), and attorney fees pursuant to section 16.

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.

K. Steffen
Signature of Arbitrator

6/5/14
Date

JUN 6 - 2014

PROCEDURAL HISTORY

This matter was presented for a hearing on the merits before Arbitrator Ketki Steffen on March 5, 2014 and March 12, 2014. Both parties were represented by counsel and have entered into several stipulations that are contained as Arbitrator's Exhibit No. 1 ("AX1") for the trial record. The disputed issues are whether Petitioner's current condition is causally related to the injury; whether the medical services provided were reasonable and necessary and if the Respondent is liable for the same; what temporary total disability ("TTD") benefits, if any, are owed the Petitioner and whether the Petitioner is entitled to any penalties or vocational rehabilitation. The Parties have further stipulated that if the Arbitrator finds that the Petitioner is at maximum medical improvement ("MMI"), the Arbitrator will also make a finding regarding permanency.

FACTUAL HISTORY

The Petitioner, Armando Avila was 55 years old at the time of the work accident of 12/8/07. He worked for the Respondent, Life Fitness as a forklift driver/stock keeper. His job entailed operating a forklift to fill order in shipping and receiving, and to move, store and stack a variety of materials. His job required the ability to consistently lift up to fifty (50) pounds. The petitioner testified that he had worked for the Respondent for nine years prior to December 8, 2007.

On the accident date, Petitioner was operating the forklift to place a pallet inside a truck on a ramp. Petitioner stated that the ramp was 4-5 feet high and as the truck started moving away from the ramp. This caused his forklift, with him in it, to fall 4-5 feet to the group. Petitioner claims that he became dazed and confused and felt some pain and stiffness in this back.

After reporting the accident to his employer, Petitioner was instructed to go to Concentra Medical Center on December 9, 2014. He returned to work the next day and worked his regular shift but had pain in his neck and back.

On December 11, 2007 the Petitioner was examined by Dr. Enrique Arana, his primary physician. He complained of back and chest pain. Dr. Arana noted on examination a positive straight leg raising test and tenderness in the lumbarsacral spine. Dr. Arana sent petitioner for X-rays of his cervical, thoracic and lumbar spine. Dr. Arana diagnosed petitioner with sprains of his cervical, thoracic and lumbar spine. (Petitioner Exhibit #2, "PX2") Dr. Arana prescribed Flexeril and motrin, physical therapy daily for two (2) weeks, and instructed the Petitioner to remain off of work for at least one (1) week. (Petitioner Exhibit #2, "PX2")

On December 18, 2007 the Petitioner was reexamined by Dr. Arana. Dr. Arana noted that physical therapy had not been approved by Worker's Compensation. The Petitioner complained of abdominal pain and blood in his stool. Dr. Arana noted that Petitioner was improving from his work injury but that the use of Motrin had caused petitioner to develop gastric pain with bleeding. He diagnosed Petitioner with an acute cervical sprain that had resolved and a lumbo-scaral sprain that was resolving. He prescribed medication a referred petitioner to a gastrointestinal specialist and released Petitioner to his full duty, regular job. Petitioner returned back to work and continued his work without any accommodations.

The Petitioner testified that he saw GI doctor at Illinois Masonic Hospital and was treated for gastritis. The petitioner further testified that he returned to work as a forklift

operator and worked his normal shift. He testified that he worked for several months and noticed increased back pain.

On May 16, 2008, the Petitioner was examined by Dr. Edward Herba of Pain Net Medical Group. PX3 Petitioner described tha accident and told the doctor that he experienced numbness and loss of feeling from the neck down to the hip and legs. He told Dr. Herbas that he felt back to normal approximately 6 weeks after the accident. Dr. Herba noted that petitioner suffered from Spinal Cord shock and recommended an X-ray of the right elbow and MRI's of petitioner's upper and lower back. PX3 The Petitioner underwent MRI's of his lumbar and cervical spine on May 20, 2008. The MRI of the lumbar spine showed a disc bulge at L4-L5 and disk herniation at L5-S1. The MRI of the cervical spine showed a C5-C6 herniated disc. PX3 Dr. Herba examined the petitioner on May 23, 2008 and diagnosed petitioner with lumbar and cervical disc herniations. Dr. Herba recommended a course of physical therapy and a visit with a pain specialist. PX3The petitioner underwent eleven (11) sessions of physical therapy at Pain Net Medical Group. The Petitioner was last examined by Dr. Herba on June 20, 2008. PX3

On June 4, 2008, Petitioner was seen by Dr. Glaser, a pain specialist. PX3 Petitioner was given options regarding his pain management and wanted to consider the steroid injections recommended by Dr. Glaser. He was instructed to continue physical therapy and was released to work full duty..

The Petitioner was examined by Dr. Gireesan on June 23, 2008. The Petitioner testified he was referred to Dr. Gireesan by his attorney. On examination, Petitioner had negative straight leg raise bilaterally. Dr. Gireesan indicated that he reviewed the

MRI of the cervical spine and found it unremarkable and lacking eny evidence of cord compression". (PX4)The MRI of the lumbosacral spine revealed the presence of a Grade I spondylolisthesis of the L4-L5 level and facet joint arthritis. Petitioner was diagnosed with facet joint arthritis. He was instructed to begin physical therapy and was released to work full duty. (PX 4. pg. 3). Petitioner testified that with the physical therapy ordered by Dr. Gireesan he noticed, "a little improvement, but it wasn't enough." (Tr. I pg. 36). Petitioner returned to Dr. Gireesan for follow-up on July 28, 2008. Petitioner informed Dr. Gireesan, "physical therapy has helped him immensely and he does have some slight plain. He informed me that overall he was significantly improved." (Px. 4 pg. 4). Petitioner returned again for follow-up on September 8, 2008 and informed Dr. Gireesan that he was feeling a lot better. (Px. 4 pg. 5). Petitioner continued to work full duty during this time.

The Petitioner underwent a course of physical therapy at ATI physical Therapy form June 25, 2008 through August 22, 2008. (Petitioner Exhibit #5, "PX5") The petitioner testified that the therapy helped relieve some of his back pain. Dr. Gireesan examined the petitioner on September 8, 2008 and noted that petitioner had completed physical therapy and was feeling a lot better. Dr. Gireesan opined that petitioner could work regular duty. PX4 The Petitioner testified that he continued working for a number of months working his regular shift. He testified that the pain in his low back and neck persisted.

The Petitioner testified that he returned to see Dr. Gireesan on January 26, 2009. Dr. Gireesan examined the Petitioner and noted complaints of pain in both elbows and

shoulders. Dr. Gireesan prescribed anti-inflammatories and instructed the petitioner to return in one (1) month. .

On January 29, 2009 Petitioner was examined by an Independent Medical Examiner, Dr. Andrew Zelby. Petitioner informed Dr. Zelby that he felt nothing at the time of the accident however about 3 days later, he started to feel pain in the low back, pain in both elbows and pain in both shoulders. Dr. Zelby examined Petitioner and concluded that Petitioner had suffered a cervical strain and a lumbar strain. (Rx. 1 pg. 10). Dr. Zelby went on to state that Petitioner was neurologically normal and had what appeared to be extremely modest abnormalities in the cervical and lumbar spine and at the most it appeared Petitioner sustained soft tissue cervical and lumbar strains. Dr. Zelby opined that Dr. Herba's suggestion that Petitioner sustained some kind of spinal cord shock was nonsense. (Rx. 1 pg. 12). Dr. Zelby further opined that based upon the findings of Petitioner's cervical and lumbar MRIs and his evaluation, Petitioner had reached Maximum Medical Improvement for any infirmity to the spine and nervous system that might have arisen as a result of his work injury in December 2009. (Rx. 1 pg. 13). Dr. Zelby concluded that additional treatment would be unnecessary and Petitioner should continue with the home exercise program for the general health of his spine and Petitioner could continue working without restriction. (Rx. 1 pg. 13).

On February 23, 2009, Petitioner returned to Dr. Gireesan. Dr. Gireesan conducted an examination and noted that the examination of the spine did not reveal any deformity. (Px. 4 Pg. 7). He suggested a lumbar corset to help Petitioner deal with the pain. Petitioner was taken off the pain medications and instructed to follow-up in one

month. (Px. 4 Pg. 7). Petitioner did not return to Dr. Gireesan again for 14 months. During this period. Petitioner continued to working for the Respondent.

On April 21, 2010 Petitioner returned to Dr. Gireesan and was sent for an MRI of his lower back and an x-ray of his lower back. (Tr. I pg. 39-40). Petitioner was sent to Northwestern Memorial Hospital. The MRI of the lumbar spine revealed very mild degenerative changes in the lumbar spine without significant central spinal canal stenosis. (Px. 4 pg. 12).

On April 26, 2010 Petitioner returned to Dr. Gireesan who recommended Petitioner undergo facet injections. (Tr. I pg. 40-41). Petitioner was referred to Dr. Engel at Marque Medicos. (Tr. I pg. 41) Petitioner did not present to Dr. Engel until April 25, 2011, almost one year later. Petitioner testified that he continued working his regular job during this time. (Tr. I pg. 41). Payroll records provided by Respondent indicate that Petitioner worked regular hours from the date of the incident through March 2012. (Rx. 4 and 5).

The Petitioner was examined by Dr. Andrew J. Engel on April 25, 2011. Dr. Engel prescribed Meloxicam, prilosec and soma compound. His diagnosis was L5-S1 discogenic pain. Dr. Engel instructed the petitioner to return in two (2) weeks with his MRI films for review. (Petitioner's Exhibit #6, "PX6") The petitioner was next examined by Dr. Engel on May 9, 2011. Dr. Engel reviewed petitioner's latest MRI and recommended pain medication, a EMG-NCV of the lower extremity along with a course of physical therapy. The petitioner underwent a EMG-NCV study of his lower extremities on May 13, 2011. Dr. Engel examined the petitioner on May 24, 2011 and recommended a series of epidural injections. PX6 The petitioner underwent an

epidural injection to his low back on June 2, 2011. PX6The petitioner testified that the injection gave him some temporary relief but that his low back pain returned a few days after his injection. The petitioner underwent physical therapy at Marque Medicos Fullerton from May 11, 2011 through August 29, 2011. PX6 The petitioner testified that the physical therapy provided very little relief to his low back pain.

The petitioner was examined by Dr. Gireesan on June 28, 2011. Dr. Gireesan recommended a MRI of the cervical spine. (Petitioner's Exhibit #3) Dr. Engel examined the petitioner on July 8, 2011 and concurred with Dr. Gireesan and sent petitioner for a MRI of his cervical spine. The petitioner underwent a MRI of his cervical spine on July 23, 2011 at Archer Open MRI. (Petitioner's Exhibit #'s 6 & 17)

Dr. Engel examined the petitioner on August 15, 2011 and recommended a EMG of his upper extremities. The petitioner underwent a EMG –NCV study of his upper extremities on August 26, 2011. Dr. Engel examined the petitioner on August 31, 2011 and recommended work conditioning followed by a functional capacity evaluation. (Petitioner's Exhibit #6) The Petitioner underwent work conditioning at Elite physical therapy for approximately four (4) weeks. The Petitioner has a FCE at Elite Physical Therapy on October 7, 2011. (Petitioner Exhibit #9) The FCE showed that petitioner demonstrated the physical capabilities to function at the Light-medium physical demand level.

The Petitioner testified that he was placed in a light duty job after the FCE by his employer. The testified that he no longer operated a forklift and basically opened and closed boxes.

The Petitioner was last examined by Dr. Engel on October 25, 2011 and January 10, 2012. Dr. Engel recommended that the petitioner follow-up with Dr. Gireesan. (Petitioner's Exhibit #6)

The Petitioner was examined by Dr. Gireesan on October 17, 2011, complaining of pain in the neck and low back. His diagnosis remained grade I spondololisthesis. Dr. Gireesan examined petitioner on November 8, 2011 and noted that petitioner was contemplating surgical intervention. Dr. Gireesan examined the petitioner on December 22, 2011 and recommended a two (2) level fusion, pending worker's compensation approval. (Petitioner's Exhibit #4} Dr. Gireesan examined the petitioner once again on February 21, 2012 and found right leg weakness and recommended a two level fusion. (Petitioner's Exhibit #4)

The Petitioner testified that he had consented to have a two –level fusion but that it was not approved by worker's compensation.

The Petitioner testified that he was notified by his employer that they could no longer accommodate his work restrictions as of March 6, 2012. He testified that he received a letter from Lori Panzarella, Human Resources Generalist. (Petitioner's Exhibit #12) The petitioner testified that he stopped working as of March 5, 2012 and has not received any worker's compensation benefits.

Dr. Gireesan examined the petitioner on March 30, 2012. Petitioner complained of low back pain with radiation into his lower extremities. Surgery was discussed and Dr. Gireesan noted that petitioner was unable to work because his employer would not accommodate his restrictions. (Petitioner's Exhibit #4)

The Petitioner testified that he received a letter from his employer advising him that his employment was terminated effective April 13, 2012. He testified that he received a letter from Lori Panzarella, Human Resources Generalist for the Respondent. (Petitioner's Exhibit #13)

The Petitioner remained under the care of Dr. Gireesan and saw him on April 17, 2012, May 15, 2012, June 11, 2012 and June 14, 2012. Surgical intervention was discussed in detail and consented to by the Petitioner. (Petitioner's Exhibit #4)

The Petitioner was next examined by Dr. Gireesan on November 8, 2012. Dr. Gireesan discussed options with the petitioner and prescribed Norco. Dr. Gireesan told petitioner that he could either have surgery or learn to live with the pain. (Petitioner's Exhibit #4) The petitioner testified that he no longer wanted to undergo surgery and decided to try and live with the pain.

The petitioner testified that he last examined by Dr. Gireesan on April 10, 2013 and June 3, 2013.

The Petitioner testified that he was examined by Dr. Andrew Zelby on January 28, 2009 and May 2, 2012 at the request of his employer. He further testified that he applied for Social Security Disability and began receiving benefits in September, 2012. The petitioner testified that he was evaluated by Susan A. Entenberg at Rehabilitation Services Associates on December 9, 2013. Susan Entenberg conducted a Vocational Rehabilitation Evaluation and issued a four (4) page report. (Petitioner's Exhibit #10)

The Petitioner testified that he completed the 6th grade in Mexico and subsequently obtained his GED in the 1980's. He testified that he can understand and

but can only write some small words in English. The petitioner further testified that he does not own or use a computer.

The Petitioner testified that his employer has not assisted him in finding a new job within his work restrictions or paid him any worker's compensation benefits. He testified that he currently experiences pain in his upper and lower back and notices numbness in both of his shoulders.

The Petitioner testified that he never injured his lower or upper back prior December 8, 2007. He further testified that he never received medical treatment to either his upper or lower back prior to December 8, 2007. The petitioner testified that he injured his right shoulder many years ago and received an Award from the Illinois Worker's Compensation commission. The Petitioner testified that he does shovel snow on occasion and shops with his wife periodically.

The petitioner testified on cross-examination that a lot of walking increases his back pain. He further testified that his lawyer assisted him in filling out questionnaire for Social Security Disability. On cross examination, the petitioner testified that he was truthful with Social Security and all of the medical providers that he treated with since his December 8, 2007 accident. He further testified on cross-examination that he has not reinjured his back, neck, shoulders and right leg subsequent to December 8, 2007.

The Petitioner admitted on cross-examination that he has not re-applied for work with Respondent or looked for a new job within his permanent work restrictions.

Dave Scimo testified at Arbitration on behalf of the Respondent. Dave Scimo testified that he is the manager of material control for the Respondent and managed the Petitioner from January of 2009 through January of 2011. He testified that petitioner

was working as a stock keeper doing picking and put-away activities. Dave Scimo testified that stock keepers must be forklift certified, have the ability to lift up to 50 pounds by hand and stand all day either operating a stand-up forklift or an order picker. Dave Scimo further testified that petitioner spends 50 percent of his day lifting boxes and the other 50 percent operating a forklift. He described petitioner's job as pretty physically demanding.

Dave Scimo testified that petitioner never complained of back pain while working as a picker. He testified that in November of 2009 he transitioned the petitioner into the put-away role. Petitioner went from picking to doing put-always. Dave Scimo testified that doing put-aways is a physically demanding job and your must be forklift certified, must be able to lift up to 50 pounds, must stand all day and handle boxes for 50 percent of the day.

Dave Scimo testified that he realized petitioner was experiencing back pain in December of 2010. He testified that he had a conversation with the petitioner who complained about having back pain. Dave Scimo testified on cross-examination that he would not have been aware of petitioner complaining of back pain from December 8, 2007 through January of 2009. He testified that he did not supervise the petitioner from December 8, 2007 through January of 2009.

Casey Raisbeck testified at Arbitration on behalf of the Respondent. He testified that the he is a field investigator and is employed by Sedgwick CMS. He testified that he conducts surveillance on claimants. He that he conducted surveillance of the petitioner on September 2, 2013, September 4, 2013 and September 17, 2013. On September 2, 2013, he observed the petitioner drive to McDonalds and then return

home. He testified that he did not witness any other activities on September 2, 2013. Casey Raisbeck testified that he observed the petitioner walk to a park with a small child on September 4, 2013. Petitioner walked approximately four blocks to Portage Park and he observed him walking, picking up a child, swinging on a swing and pushing another individual on the swing. Petitioner was in Portage Park for around an hour to an hour and a half.

Casey Raisbeck also testified that he observed the petitioner on September 17, 2013, walking to the park with a small child in a stroller.

Casey Raisbeck testified on cross examination that the child he observed during his surveillance was approximately two to three years old and weighed about 18 to 25 pounds. He further testified that the child was walking on its own during most of his surveillance of the petitioner.

Peter Han testified at Arbitration on behalf of the Respondent. He testified that he is a private investigator employed by Sedgwick CMS. He testified that he conducted surveillance of the Petitioner on September 2, 2013, September 4, 2013 and September 17, 2013. He observed the Petitioner on September 2, 2013 driving his Toyota Camry into the alleyway near the rear of his residence. Petitioner exited his vehicle, conversed with a neighbor for about fifteen minutes and then removed two twelve pack of soda from his trunk. Peter Han testified that he observed the Petitioner on September 4, 2013 waking with a small child. He testified that the Petitioner momentarily picked up the child and then put the child back on the ground. He testified that his observation on September 4, 2013 were pretty minimal. He stated that his observations of the petitioner on September 4 and 17 of 2013 and were minimal.

ANALYSIS/FINDINGS

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY CONNECTED TO HIS INJURY?

The Arbitrator finds that Petitioner's current condition of ill-being relating to his back is not causally related to the alleged injury.

It is uncontroverted that Petitioner was involved in a work accident in which his forklift fell 4-5 feet with him in it. He received medical care and returned to work after a 2 week medical leave. After that Petitioner continued to work in his full duty capacity without restriction until March 5, 2014. Petitioner was treated conservatively with therapy, pain medications and opted to forgo a recommended fusion surgery. There are no complaints to his supervisors and although the Petitioner started doing stocking work, evidence shows that such work was of a equal physical demand as his prior assignment.

Dr. Gireesan was Petitioner's treating physician and Dr. Zelby was the independent medical examiner in this case. Dr. Gireesan treated petitioner for almost five years and diagnosed Petitioner with a Grade 1 Spondylolistehsis of L4 and L5 with facet joint arthritis, aggravated as a result of work injury. (Petitioners, Ex. 4) He opined that petitioner's work injury aggravated a per-existing condition of spondylolisthesis and this necessitates a single level fusion.

Dr. Zelby, the IME examined the Petitioner and opined that he has suffered a cervical strain and a lumbar stain (Respondent's Ex. 1, pg. 10) His medical conclusion was that Petitioner was neurologically normal and had modest abnormalities in the cervical and lumbar spine. His diagnosis was that Petitioner sustained soft tissue cervical and lumbar strains. Dr. Zelby opined that he strongly disagreed with Dr. Herba's

suggestion that Petitioner sustained some kind of spinal cord shock. (Rx. 1 pg. 12). Dr. Zelby further opined that based upon the findings of Petitioner's cervical and lumbar MRIs and his evaluation, Petitioner had reached Maximum Medical Improvement for any infirmity to the spine and nervous system that might have arisen as a result of his work injury in December 2009. (Rx. 1 pg. 13). Dr. Zelby concluded that additional treatment would be unnecessary and Petitioner should continue with the home exercise program for the general health of his spine and Petitioner could continue working without restriction. (Rx. 1 pg. 13).

Petitioner's continued to work full unrestricted duty and told Dr. Gireesan in July, 2008 that his symptoms were significantly improved with physical therapy. In fact, Petitioner did not treat September 2008 through January 2009, had repeated negative physical examinations and diagnostic tests. and on January 26, 2009, Dr Gireesan notes a diagnoses of generalized osteoarthritis. (Px. 4 pg. 6). Thereafter there is little indication of Petitioner treating for the next 14 months. Subsequent testing at Northwestern Hospital shows mild degenerative changes and a May 13, 2011 EMG of his lower back and a August 26, 2011 EMG. (PX. 6 pg 34). of his upper back are normal. (Px. 6 pg. 34, 37). Petitioner continues to work full duty.

The Arbitrator finds Dr. Zelby's opinions to be more credible than Dr. Gireesan's opinions.. Dr. Zelby's opinions are substantiated by the objective findings contained in Petitioner's medical records. Dr. Zelby's opinion is supported by the findings of Dr. Arana, who first treated Petitioner on December 11, 2007 (three days after the injury) and diagnosed him with a muscle strain. . (Px. 2 pg. 2). Diagnostic testing that was conducted that same day shows a normal cervical spine without evidence of fracture or

alignment abnormality; a normal thoracic spine and degenerative changes in the lower thoracic spine with marginal osteophytes. (Px. 2 pg. 2-3)The the lumbar spine revealed no fracture or spondylolysis, mild grade I spondylolisthesis L4 over L5 probably related to associated facet arthropathy L4 through S1; and the sacrum coccyx was normal. (Px. 2 pg. 3). Therefore, Dr. Arana's findings and diagnostic testing conducted after the accident support the finding and conclusion of Dr. Zelby.

Dr. Gireesan's findings are also given lesser weight by the Arbitrator based on a closer review of the testimony and conclusion contained in the medical records and the deposition of Dr. Gireesan. On Petitioner's first visit to Dr. Gireesan's office, he was found to have negative straight leg raise bilaterally. Dr. Gireesan indicated that he reviewed the MRI of the cervical spine and, "it was unremarkable." On a follow-up exam of from July 28, 2008 to September 8, 2008 Dr. Gireesan notes that physical therapy has helped Petitioner immensely, that he is "significantly improved." (Px. 4 pg. 4) and feeling a lot better. (Px. 4 pg. 5).

During his evidence deposition, Dr. Gireesan testified that Petitioner did not have a disc herniation in all of the MRI's that he reviewed and that the decreased hydration in the disc was age related and that it was not unusual for someone of Petitioner's age. (Px. 11 pg. 48). Dr. Gireesan also acknowledged that Petitioner had the degenerative findings in the facet joints and disc spaces prior to the accident. (Px. 11 pg. 49). Dr. Gireesan stated that on July 28, 2008, Petitioner's exam was normal and that on the September 8, 2008 appointment, Petitioner appeared to have returned to baseline. (Px. 11 pg. 52-54). Lastly, Dr. Gireesan agreed that even without an accident Petitioner

could have generalized pain that included neck, shoulders, elbows, low back because he had a degenerating spine, more specifically an arthritic condition. (Px. 11 pg. 57).

In addition to weighing and comparing the testimony and findings of the medical providers, the Arbitrator has also considered the considered the surveillance tapes, witness testimony and Petitioner's credibility in evaluating the claims. The surveillance tape show Petitioner engaged in family activity with his grand child and walking and talking to a neighbor. At first blush, the tapes capture Petitioner in a normal activity. However, the Petitioner has testified in court about severe physical limitations and has given written descriptions of his disabilities to the Social Security office and to his FCE evaluator. The tapes and Petitioner's physical capabilities as witnessed on them are in utter conflict which what Petitioner has testified to and what he has related to his evaluators. The Arbitrator finds the tapes to be impeaching and finds that the Petitioner can functioning at a level higher then he has testified to or revealed to treatment provideres/evaluators. The testimony of the Respondent's witness Dave Scimo also undermines Petitioner's case.

The Arbitrator finds that the Petitioner may have some pain complaints but that the pain is not due to the work accident but rather due to arthritic condition and the natural aging process. The basis for this finding is that the Arbitrator finds upon the review of medical testimony that Petitioner suffered a back sprain which healed with conservative therapy and passage of time. The strongest proof of this is that Petitioner continued to work for four years after his accident without any surgical intervention, had long gaps between treatment and there are no objection findings that support that Petitioner's sprain injuries were anything beyond temporary.

Therefore, the Arbitrator finds that the Petitioner's current condition of ill-being is not causally related to the work accident but that the Petitioner' injuries healed after conservative treatment on or about January 28, 2009.

J. WAS PETITIONER'S MEDICAL TREATMENT REASONABLE AND NECESSARY? IS RESPONDENT LIABLE FOR OUTSTANDING MEDICAL BILLS?

The Arbitrator finds that Petitioner's was involved in a work accident that injured his back but that he recovered from his work injuries through conservative medical treatment on or about January 28, 2009. The arbitrator finds that additional medical treatment after January 28, 2009 were unrelated, unreasonable and/or unnecessary.

Petitioner was treated primarily by Dr. Gireesan and reported as early as July 2008 that that his symptoms were significantly improved with physical therapy. His physical examinations and diagnostic tests were negative. There is little objective support for continued medical treatment. When Petitioner returned to Dr. Gireesan on January 26, 2009, after 5 months, he was diagnosed with generalized osteoarthritis. (Px. 4 pg. 6).

On January 28, 2009 Petitioner presented for an Independent Medical Evaluation with Dr. Zelby, Dr. Zelby found Petitioner to be neurologically normal and further opined that based upon the findings of Petitioner's cervical and lumbar MRIs and his evaluation on January 28, 2009, Petitioner had reached Maximum Medical Improvement for any infirmity to the spine and nervous system that might have arisen as a result of his work injury. (Rx. 1 pg. 12-13) Dr. Zelby went on comment that Petitioner continued to do well and that it seemed likely that Petitioner was at maximum medical improvement by September 2008. (Rx. 1 pg. 16-17).

After the IME visit Petitioner went without any medical treatment for additional 14 months. Subsequently tests were conducted at Northwestern Memorial Hospital on April 21, 2010 (mild degenerative changes) and Petitioner again went untreated for one year. Ultimately Petitioner presented to Dr. Engel at Marque Medicos but his straight leg raise was negative bilaterally. (Px 6). A May 13, 2011, EMG for the lower back and an EMG for his upper back on August 26, 2011 were also normal. Petitioner presented for the EMG of his lower back which was found to be a normal study. (PX. 6 pg 34, 37).

In spite of these results, Dr. Engel referred Petitioner to physical therapy at Marque Medicos. Petitioner did not act upon this referral for almost a year and ultimately received physical therapy there for about three month with a total bill of $36,090.00. Petitioner stated that the therapy did not help him and that he was unaware of the extremely high cost of the same. (Tr. I pg.102)

The Arbitrator finds that the Petitioner has not exceeded his number of allowed physicians under §8(a)(3) of the Act. Petitioner testified that he treated with a number of physicians but that this was based on a referral by his physician of choice. Therefore, the Petitioner has not exceeds the number permitted under §8(a)(3) of the Act.

However, based on the finding that on January 28, 2009 Petitioner was found to be MMI by Dr. Zelby with a reasonable follow up visit with his own physician Dr. Gireesan on February 23, 2009, the Arbitrator awards medical bills till this date of February 23, 2009 subject to fee schedule and as relating to Petitioner's work accident and treatment. It is of significance to the arbitrator that Petitioner does not treat or return to his physician for 14 months after this date and continues to work full time.. The Arbitrator finds the treatment after such date to be unrelated and unreasonable and

unnecessary. The Arbitrator specifically finds that the treatment at Marque Medicos meets all of these criteria.

The awarded awards medical bills till the date of February 23, 2009 may be paid by Respondent directly pursuant to the Medical Fee Schedule or other contractual arrangement that the carrier may have with the provider. Petitioner is to be held harmless for such bills. Respondent may also request a certified copy and/or a current statement and balance on such bills.

K. WHAT TTD BENEFITS ARE OWED THE PETITIONER?

Petitioner claims to be entitled to TTD benefits from March 6, 2012 through March 4, 2014, representing 104 1/7 weeks pursuant to AX1 which contains the issues that are stipulated in this case and the matters that are in dispute. The Arbitrator finds that the Petitioner is entitled to TTD benefits from December 11, 2007 through December 25, 2007, which represents a period of 2 weeks when Petitioner was off work due to his work accident. Subsequently, Petitioner returned to work and continued working full duty for the next four years, up until October 2011 when he was placed on light duty. Petitioner was MMI prior to October, 2011.

Therefore, Petitioner's is awarded TTD benefits for the two weeks from December 11, 2007 through December 25, 2007.

L. NATURE AND EXTENT

Arbitrator finds that the Petitioner has not suffered permanent disability from this work accident and is therefore not entitled to a permanency award. Although it is true that Petitioner worked as a stocking keeper within his medically prescribed restrictions, the Arbitrator finds that those restrictions were unrelated to the work accident. The

Arbitrator finds that these restrictions were the result of degenerative disc disorder and other conditions, such as age.

The foundation and support for this finding is that the Petitioner willingly and easily returned back to work two weeks after the accident and continued to perform well in his full duty and capacity. Petitioner's work duties were medium to heavy and he came back to his work duties and continued to do them without incident till October, 2011, a period of almost 4 years. His job duties as a Stock Keeper required the ability to, "operate measuring/weighing devises and forklift trucks and to be able to consistently lift up to 50 lbs." (Rx. 7). Petitioner worked in his physically demanding capacity as as corroborated by the testimony of Mr. Scimo, his supervisor. In October, 2011 following a work conditioning program at Elite Physical Therapy, Petitioner was placed in a light to medium capacity job which he continued till 3/5/12. Mr. Scimo testified that Petitioner's job in the lighter duty capacity was almost as physically demanding job as his prior job because 100% of the day was spent standing. The payroll records also indicate that Petitioner worked his regular hours before and after the alleged incident on December 8, 2007. (Rx. 5). Petitioner documents no complains to his employer about his difficulty to do his demanding job for a period of four years.. In the Arbitrator's opinion, this is an important and telling factor that Petitioner did not suffer permanent disability as a result of his work accident. Some of Petitioner's complaints are a result of arthritic changes and age related issues while others appear to be contrary to the objective, clear findings on the video graphic evidence.

Medical opinions and other witness testimony produced at the hearing also support this conclusion. Witness Dave Scimo testified that Petitioner was able to work

as a stock keeper and then as a put-away stock keeper which is a very physically demanding job. He testified that Petitioner was required to lift up to 50 lbs, stand, bend and operate a forklift. Petitioner was able to perform these job functions, full time, for four years after his accident.

Petitioner now testifies in court that he he has severe physical limitations. He testified that he cannot be seated too long and that his shoulders are always numb. He complained of pain going down both arms, numbness in both hands and a radiating pain down his right leg. In Social Security Administration application, he states he cannot lift heavy objects, sit or stand for extended periods of time, his injury impacts his ability to lift, bend, stand, reach walk, sit, and kneel, stair climb and was only able to walk one block before needing to stop and rest. (Tr. I pg. 78-80). In conjunction with his application he states that he requires the use of banisters to climb stairs. (Tr. I pg. 85) and that he experienced pain when he walks more than two blocks. He also reported that he cannot lift anything more than 20 lbs. (Tr. I pg. 85).

Petitioner told Susan Entenberg, a vocational rehabilitation counselor that he had constant low back pain after walking 3 to 4 blocks, constant tightness in his ears, back and neck and that he that he was unable to walk more than 3 to 4 blocks without needing to rest. (Tr. I pg. 74-76).

Petitioner's testimony in court and his statements to treatment providers and other evaluators does not comport with what has been described by witness Dave Scimo as Petitioner's actual physical abilities and what is witnessed on the surveillance tapes. The statements in court and the documented statements to these evaluators are also mutually conflicting and inconsistent. The surveillance videos show Petitioner

climbing stairs without using the banister; standing and talking to a neighbor for 43 minutes; walking four blocks to a park, picking up a child, walking around the park, standing, and walking back home another four blocks; and then walking to and from the park again on another day. The Arbitrator finds that the videos show that Petitioner is significantly more capable than he alleges and that his statements as to his pain and injuries seem to be somewhat inflated. This lessens Petitioner's credibility regarding his abilities. Even if his current complaints are taken at face value, the Arbitrator finds that these are not work accident related but may be the result of the aging process and advancing arthritic condition. How else could a man that states he cannot be seated too long work at the physically demanding job as the Petitioner did for four long years?

The Arbitrator finds that Petitioner suffered a work accident, received treatment and returned to work a very physically demanding job for almost 4 years after the accident. This shows that the work accident did not permanently interfere with Petitioner's ability to work. His allegations regarding his inability are proven to be somewhat inflated based on the video and/or are caused due to the natural progression of age and his degenerative disc condition.

Therefore, Arbitrator finds that the Petitioner has not proven that he suffered a permanency due to his work accident.

M. IS PETITIONER ENTITLED TO PENALTIES AND ATTORNEY'S FEES?

Petitioner had sought Penalties under sections 19(k) and 19(l) or Attorney's fees under section 16. (AX1) The arbitrator finds that the Respondent's conduct was neither unreasonable nor vexatious in the defense of this claim as they relied on the the opinion

of a board certified neurosurgeon and the Petitioner has worked at this full duty capacity after the accident for four years.

Therefore, the Arbitrator denies the request for penalties and fees.

O. IS PETITIONER ELIGIBLE FOR VOCATIONAL REHABILITATION?

The Arbitrator finds that Petitioner is not entitled to vocational rehabilitation because his current condition of ill being is not causally related to the accident. Additionally Petitioner is receiving Social Security Disability benefits and has admitted that he is not looking to work.

K. Steffen
Arbitrator Ketki S. Steffen

June 6, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KENNETH C. BENSFIELD,

Petitioner,

vs. NO: 12 WC 41278

VILLAGE OF BROOKFIELD,

15IWCC0617

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, 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, 35 Ill.Dec. 794 (1980).

The Commission modifies the medical award to reduce the amount for Orthopedic Associates of Riverside from $12,793.00 to $12,500.00, which is the amount listed on the bill in Px10. The Commission finds that the $160.00 bill for Dr. Edward Tong (Px12) is not supported by any medical records in evidence and is hereby denied. The bill for $35,099.34 to MacNeal Hospital is affirmed. All of these medical expenses shall be paid subject to the fee schedule in Section 8.2 of the Act.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent shall pay to the Petitioner the sum of $1,026.00 per week for a period of 95-5/7 weeks, that being the period of temporary total incapacity for work under §8(b), and that as provided in §19(b) of the Act, this award in no instance shall be a bar to a further hearing and determination of a further amount of temporary total compensation or of compensation for permanent disability, if any.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $47,599.34 for medical expenses 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 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. Respondent shall hold Petitioner harmless for any claims by any providers of the services for which Respondent is receiving credit under §8(j) of the Act.

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

DATED: AUG 1 2 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 7/14/15
49

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

BENSFIELD, KENNETH C
Employee/Petitioner

Case# **12WC041278**

VILLAGE OF BROOKFIELD
Employer/Respondent

15IWCC0617

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0412 RIDGE & DOWNES
MATTHEW COLEMAN
101 N WACKER DR SUITE 200
CHICAGO, IL 60606

0075 POWER & CRONIN LTD
JOHN P FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Kenneth C Bensfield
Employee/Petitioner

v.

Village of Brookfield
Employer/Respondent

Case #**12** WC **41278**

15IWCC0617

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **February 18, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **April 20, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$80,028.00**; the average weekly wage was $**$1,539.00**.

On the date of accident, Petitioner was **54** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**67,386.47** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**67,386.47**.

Respondent is entitled to a credit of $**34,824.34** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**1,026.00**/week for **95 5/7^{ths}** weeks, commencing **April 20, 2012** through **February 18, 2014**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **April 20, 2012** through **February 18, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $**67,386.47** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $**12,793.00** to **Orthopedic Associates of Riverside**, $**35,099.34** to **MacNeal Hospital**, and $**160.00** to **Dr. Edward Tong**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $**34,824.34** 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.

Credits

Respondent shall be given a credit of $**67,386.47** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**67,386.47**.

Respondent shall be given a credit of $**34,824.34** 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 have credit for all amounts paid, if any, to or on behalf of petitioner on account of said accidental injury.

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

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

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

Signature of Arbitrator

June 30, 2014
Date

JUN 30 2014

ICArbDec19(b)

FACTS

Petitioner was the only witness to testify. Petitioner is employed as a firefighter and emergency medical technician for Respondent. Petitioner testified that on April 20, 2012, he was instructed to paint the hose tower, a platform approximately two and half stories high, where wet hoses are hanged for drying. Petitioner testified that he climbed a wall mounted ladder to the platform. Petitioner testified that the area is designated as a hard hat area, but that no hard hats were available, so he used his fire helmet. Petitioner testified that he also wore a body harness. Petitioner testified that, unlike a hard hat, the fire helmet has a front and back brim for protection. Petitioner testified that he never finished painting. Petitioner testified that as he was transferring to a lower platform his fire helmet brim became wedged on top of a spindle, and he started to become strangled by the helmet chin strap. Petitioner testified that he believed his entire body was being held up by his helmet. Petitioner testified that he struggled with his left arm to remove his helmet. Petitioner testified that he heard popping in his back and neck. Petitioner testified that he received medical treatment and walked to the ambulance.

Petitioner testified that he was taken to Loyola University Medical Center emergency room. Petitioner was treated for facial and neck injuries. CT scans indicated bulging discs. He was prescribed pain medications and was released (RX3).

Petitioner returned to Loyola on April 22, 2014 complaining of worsening pain which was spreading from his neck to his back and left scapular area. He was prescribed stronger pain medication and instructed to follow up with Dr. Alpesh Patel, an orthopedic surgeon (RX3).

Petitioner was examined by Dr. Patel on May 4, 2012. Dr. Patel's initial impression was a cervical strain injury and a possible cervical radiculopathy versus myelopathy, possible peripheral nerve injury, and possible upper extremity injury. Dr. Patel ordered a cervical spine MRI, which was performed on May 7, 2014. Petitioner returned to Dr. Patel on May 11, 2012. Dr. Patel reviewed the MRI, which showed disc degeneration and spondylotic changes at C4 – C5 with bilateral foraminal stenosis left side equals the right side. C5 – C6 showed mild degenerative changes with right-sided foraminal stenosis. C6 – C7 showed some degenerative changes broad-based posterior disc bulge with no central or foraminal stenosis. No spinal cord signal change was noted. There was no ongoing spinal cord compression. Dr. Patel prescribed physical therapy for the neck and lower back, and he referred Petitioner to Dr. Lawrence Frank for nonoperative treatment of the neck and lower back and to Dr. Guido Marra for evaluation of the left shoulder (PX1).

On May 24, 2012, Petitioner was examined by Dr. Marra, who recommended that an MR athrogram be performed to evaluate for a possible labral tear. Petitioner returned to Dr. Marra on June 21, 2014. The MRI scan showed evidence of an anterior laberal tear. Dr. Marra was leaving Loyola for Northwestern, so he provided the names of Dr. Tonino and Dr. Evans for continued treatment (PX4).

Petitioner was examined by Dr. Patel on June 29, 2012 and complained of ongoing symptoms. Dr. Patel indicated the possibility of epidural injections, lower back surgery, and cervical spine surgery. Dr. Patel recommended a lumbar spine MRI before definitive surgical and nonsurgical treatment plan. Petitioner was examined by Dr. Patel on July 24, 2012. The neck pain and left upper extremity shoulder pain symptoms had improved somewhat with physical therapy but were still persistent with left-sided shoulder pain. The MRI was reviewed and showed mild degenerative changes mostly noted at the L4- L5 and L5- S1 segments. There was disc space collapse noted at the L5- S1 segment. There was left-sided foraminal stenosis at the L5- S1 segment. Dr. Patel's impression was left L5- S1 stenosis with radiculopathy and C4-C5 spondylosis with radiculopathy left-sided. Operative and nonoperative options were discussed, and Petitioner opted for conservative nonoperative measures. Dr. Patel referred Petitioner to Dr. Frank for a left-sided C5 selective nerve root injection (PX1).

Petitioner was then seen by Dr. Frank who administered the injection treatment. Petitioner had follow up appointments with Dr. Frank on August 13, 2012 August 30, 2012 September 20, 2012 and October 15, 2012. Dr. Frank charted that Petitioner had exaggerated symptoms and that Petitioner could not return to unrestricted work (PX5).

Petitioner then returned to Dr. Patel for continuing medical treatment. Dr. Patel authored a May 28 2013 report in which he opined that Petitioner had underlying cervical degenerative disc disease and underlying lumbar degeneration which were non-symptomatic and then were aggravated by the work injury. Dr. Patel further stated that Petitioner would not be able to return to full duty work (PX3).

Dr. Daniel Troy examined post accident records and examined Petitioner on January 27, 2013 at Respondent's request. Dr. Troy opined that Petitioner sustained a temporary aggravation of a pre-existing degenerative change at the C4-C5 level. Dr. Troy further opined that Petitioner's left shoulder strain had aggravated preexisting chronic degenerative changes of the labrum. Dr. Troy further opined that Petitioner sustained a lumbosacral strain with aggravation of significant preexisting degenerative changes at the L5-S1 level. Dr. Troy testified at an evidence deposition, at which time he reiterated all of his opinions (RX1).

Dr. Marra authored an August 22, 2013 report in which he described Petitioner's medical treatment and opined regarding Dr. Troy's report. Dr. Marra opined that an acute injury to the labrum cannot be excluded and that if there were evidence of previous shoulder instability then he would agree with Dr. Troy's opinion (PX4).

Petitioner has subsequently obtained medical treatment from Dr. Michael Hejna, an orthopedic surgeon. On February 3, 2014 Dr. Hena performed arthroscopic left shoulder superior labral anteroposterior repair and open rotator cuff repair (PX7).

Petitioner remains off of work. Respondent has disputed Petitioner's temporary total disability benefits and medical benefits after the receipt of Dr. Troy's report.

Petitioner has initiated contemporaneous proceedings before the Brookfield Firefighters Pension Board. That statutory proceeding involves three independent medical examinations. Petitioner testified that he has undergone two examinations thus far. Petitioner was examined by Dr. David M. Anderson on August 6, 2013. Dr. Anderson opined that Petitioner's conditions are related to his work accident and that he is disabled from

fire service (PX13). Petitioner was examined by Dr. Babak Lami on August 16, 2013. Dr. Lami opined that Petitioner's condition was preexisting, that Petitioner's condition of ill-being was not consistent with the mechanism of injury, that Petitioner's subjective complaints were inconsistent with and out of proportion to his objective findings, and that Petitioner was capable of returning to his full and unrestricted duties (RX2).

CAUSATION

Petitioner had underlying degenerative cervical and lumbar spinal conditions, which were aggravated by his work injury. Petitioner complained of neck injuries on the date of the accident. Petitioner's treating physicians have charted that his injuries are work-related. Petitioner's testimony that his low back symptoms reached clinical expression two days after the accident is corroborated by the medical records. Dr. Troy's opinions that all of the Petitioner's injuries were pre-existing and that none of the Petitioner's injuries were caused by the accident are not persuasive. Dr. Troy testified that he reviewed post accident records only. Dr. Marra opined that he would agree with Dr. Troy's opinion if there were evidence of previous shoulder instability. However, there is no such evidence, and Dr. Troy has not reviewed any pre-accident records. Dr. Lami's opinion that Petitioner's condition of ill-being was not consistent with the mechanism of injury and that Petitioner was capable of returning to full-time and unrestricted duties runs contrary to the medical treatment records.

The Arbitrator is aware that Dr. Frank noted exaggerated symptoms. However, Dr. Frank further noted that Petitioner could not return to unrestricted work due to his symptoms.

Based upon the foregoing, the arbitrator finds that Petitioner's current condition of ill being is causally related to the accident.

MEDICAL

Respondent's dispute on this issue is premised upon causation, which has been resolved in favor of Petitioner.

Therefore, the claimed medical benefits shall be awarded.

TEMPORARY TOTAL DISABILITY

Respondent's dispute on this issue is premised upon causation, which has been resolved in favor of Petitioner.

Therefore, the claimed temporary total disability benefits shall be awarded.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK HARKIN,

Petitioner,

vs. NO: 13 WC 17347

GURTZ ELECTRIC,

15IWCC0618

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) was filed by the Respondent Lend Lease herein and notice given to all parties. The Commission was asked to consider the issues of causation and prospective medical on Review.

The Commission notes that the Arbitrator issued a single decision with regard to the consolidated claims 13 WC 17347 and 13 WC 37350, and that decision listed both Gurtz Electric and Lend Lease as parties respondent. However, per the Application for Adjustment of Claim, the case at bar, 13 WC 17347 was filed against only Respondent Gurtz Electric. As such, Respondent Lend Lease has no liability and no standing to file a Petition for Review on 13 WC 17347. Based on this finding, the review in 13 WC 17347 is hereby dismissed with prejudice. 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).

A separate decision will be issued on Review by the Commission in case number 13 WC 37350. Because the Review in this matter has been dismissed with prejudice, we have

15IWCC0618

determined that there is no bond required of Respondent, should this matter be appealed to the Circuit Court.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Review of this matter, filed by Respondent Lend Lease, is hereby dismissed.

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.

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

DATED: AUG 1 2 2015
TJT: pvc
O 06/16/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(a)

HARKIN, PATRICK
Employee/Petitioner

Case# **13WC017347**
13WC037350

GURTZ ELECTRIC COMPANY
Employer/Respondent

15IWCC0618

On 7/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0579 FRIEDMAN AND SOLMOR
GARY B FRIEDMAN
200 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
STUART PELLISH
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1739 STONE & JOHNSON CHARTERED
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CHICAGO, IL 60602

15IWCC0618

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
8(a)

Patrick Harkin
Employee/Petitioner

v.

Consolidated cases #: **13 WC 17347; 13 WC 37350**

Gurtz Electric 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 **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **May 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accidents, **8-7-12; 10-21-13**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being ***is*** causally related to the accident of October 21, 2013.

In the year preceding the injury, Petitioner earned $**86,987.68**; the average weekly wage was $**1,672.84**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

ORDER

Petitioner's current condition of ill being to his lower back is related to the October 21, 2013 accident. Respondent in Claim 13 WC 037350, the October 21, 2013, accident is hereby ordered to authorize the proposed lumbar surgery at L5-S1.

13 WC 017347, the August 7, 2012 accident, petitioner's request for an order directing Respondent to authorize the proposed lumbar surgery at L5-S1 is hereby denied.

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

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

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

Signature of Arbitrator

7/24/14
Date

ICArbDec19(b)

JUL 28 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK HARKIN, Petitioner, v. GURTZ ELECTRIC COMPANY Respondent.	No.: 13 WC 17347 ; 13 WC 37350

FINDINGS OF FACT

Petitioner was involved in two accidents while working for Respondent. Respondent is insured by two separate workers compensation carriers for each accident. The sole issue at bar is which carrier is responsible for the prescribed surgery. Neither carrier raises an issue as to the necessity of such surgery.

13 WC 17347

Petitioner is an electrician, employed by the Respondent since October 15, 2004.

On August 7, 2012, Petitioner was lifting a heavy reel of cable onto a jack. He lost his footing, causing him to slip and fall. He injured his right shoulder and elbow, his left knee and his lower back. Petitioner testified that immediately following the accident, he felt intense pain in his lower back and pain in his right leg.

Petitioner testified that for the ten years preceding August 7, 2012, he had no accidents, treatment or problems with his lower back.

Petitioner came under the care of Dr. Scott Cordes who provided treatment from August 9, 2012, to August 27, 2013. Petitioner testified that when he began treating with Dr. Cordes he could hardly walk or stand due to his lower back pain.

Petitioner underwent several surgeries following and related to the August 2, 2012, accident. The surgeries involved his right shoulder, right elbow and left knee. The parties concur that the above mentioned surgeries are unrelated to the matter before the Arbitrator.

An August 20, 2012, MRI of Petitioner's lumbar spine revealed:

a mild disk bulge and a superimposed small right paracentral disk protrusion at L5-S1 resulting in mild dorsal displacement of the descending right S1 nerve root. (PX2)

On September 26, 2012, Dr. Mehta noted that Petitioner presented with lower back pain radiating into the right leg. The doctor noted complaints of numbness and tingling with some weakness in the right leg.

On October 2, 2012, Dr. Mehta administered a steroid injection into the right L5-S1 region of Petitioner's lower back.

Between March 2, 2013 and August 19, 2013, Petitioner participated in physical therapy. Between July 24 and August 19, 2013, the physical therapy included work conditioning.

In the August 12, 2013, work conditioning progress note, the therapist noted that medium level work may be appropriate for Petitioner and that Petitioner was uncertain if he could perform the necessary stair climbing, lifting, and carrying. At the last physical therapy/work conditioning session on August 19, 2013, the therapist documented that Petitioner's back was sore following the last work conditioning session. The therapist recommended additional work conditioning. (RX 3.)

Petitioner testified that he underwent an FCE, but no FCE was contained in Athletico's or Dr. Cordes' records. (PX 5, PX 1.) Petitioner returned to Dr. Cordes on August 20, 2013 and reported that work conditioning aggravated his back. Dr. Cordes permitted Petitioner to return to work with a 20 pound lifting limit. (RX 1.)

On August 27, 2013 Petitioner returned to Dr. Cordes and advised that light duty was not available, and that he did not want to return to work conditioning. Dr. Cordes released Petitioner to full duty on August 27, 2013. (RX 1.)

Petitioner was off work pursuant to Dr. Cordes' orders from January 13, 2013 through August 27, 2013.

Petitioner testified that after participating in sixty-five hours of physical therapy his lower back pain improved.

On August 29, 2013, Petitioner returned to work. He described his duties as installing conduit which required working on a ladder and working overhead. He continued to have pain in his lower back radiating into the right leg. Petitioner testified that he returned to work because Dr. Cordes told him there was no effective treatment that he could provide. (RX 1.)

Petitioner continued working full time, full duty, for nearly two months.

On October 21, 2013, Petitioner suffered a second accident. Petitioner was standing on a scissor-jack and jumped into the air to avoid stepping on a nail. Petitioner testified he felt severe pain in his low back that radiated down his right leg into the right ankle. For the first few days, it was difficult for Petitioner to straighten up or walk. Petitioner went to Concentra on October 21 and October 23, 2013. The physician at Concentra on October 23 ordered light duty and referred him to an orthopedist.

On November 6, 2013, Petitioner presented to Dr. Nolden who noted low back, right hip, groin, and posterior thigh pain. Petitioner told Dr. Nolden that he initially injured his low back with right radiating symptoms in August of 2012. Petitioner assessed his symptoms as 70% alleviated when he returned to "light duty". Petitioner assessed his pain as ranging between 3/10 and 5/10. He also complained of constant right hip pain and intermittent right groin pain. Dr. Nolden ordered an MRI of the lumbar spine. (RX 4.)

On November 12, 2013, Petitioner underwent a lumbar MRI.

On November 13, 2013, Petitioner returned to Dr. Nolden to review the MRI. Dr. Nolden indicated the MRI showed a herniated disc at L5-S1 resulting in dorsal displacement of the right S1 nerve root. The doctor also indicated that the herniation was missed by the radiologist. Dr. Nolden recommended a minimally invasive microdiscectomy at L5 – S1.

Petitioner testified he currently takes anti-inflammatories for pain.

Petitioner testified that he wants the surgery recommended by Dr. Nolan.

Petitioner was examined by Dr. Zelby at the request of the Respondents in 13 WC 37350 on January 15, 2014. Petitioner provided a consistent history of both accidents. Dr. Zelby reviewed and compared the two MRIs of the lumbar spine. Both MRIs showed a herniated L5-S1 disc on the right, consistent with his symptoms. Dr. Zelby agreed that surgery was appropriate. (RX 5.) A Utilization Review report concurred that surgery was reasonable and necessary. The UR report did not include a review of the medical records prior to October 21, 2013. (PX 4A.)

Petitioner testified that he can walk and drive although after sitting or walking for a certain amount of time his pain increases. The light/restricted duty work is difficult for him because he is in a lot of pain.

Petitioner testified that he thinks his low back pain increased following the October 21, 2013 accident.

CONCLUSIONS OF LAW

The fact that Petitioner was experiencing pain and discomfort both prior to and when he returned to work is not surprising. He had not worked for a year following the first accident. The fact he noticed pain while undergoing work conditioning is also not surprising. Petitioner was being pushed by the therapist to perform activities to mimic work activities that he had not performed in nearly a year.

The pain and discomfort verbalized by Petitioner upon his return to work is viewed as an indication he might have suffered permanent residuals to his back from the August, 2012. It is not dispositive of which carrier is responsible for the prescribed lumbar surgery.

The Arbitrator notes that surgery was never recommended with respect to the first accident. None of the treating physicians nor the examiner, Dr. Zelby, render any medical opinion finding the necessity of the surgery was due to the first accident. The Arbitrator cannot overlook the absence of such opinion from Dr. Zelby. If the necessity for the surgery was due to the August, 2012, accident, as the carrier for the October 21, 2013 contends, it would have been expected Dr. Zelby would have opined the October 21, 2013 accident was a temporary aggravation of L5-S1 disc pathology but that the recommended surgery was solely attributable to the earlier August 2012 accident. Dr. Zelby makes no such statement.

When he examined Petitioner, Dr. Zelby took a history. His January 15, 2014 report noted comments of Petitioner that the October 21, 2013, accident occurred, brought an increase in his low back pain and right leg pain to the same severity following the first accident.

Dr. Zelby's report notes that the November 12, 2013, MRI shows mild progression of the degenerative disc disease, most notably at L5-S1. Dr. Zelby also noted Dr. Nolden's November 13, 2013 note, where Dr. Nolden indicated that the most recent MRI showed a herniated disc at L5-S1 resulting in dorsal displacement of the right S1 nerve root.

The Arbitrator notes the prescription for surgery did not occur until after the October 21, 2013, accident. There is no evidence in the record that surgery was recommended with respect to the first accident.

Dr. Nolden's November 13, 2013, progress note indicates Petitioner was seen on November 6, 2013, for diffuse low back pain with radiation into the buttocks, right hip, right groin and posterior thigh after being involved in a work injury on October 21, 2013.

The Arbitrator concludes, based on the Petitioner's testimony and her review of all medical records and reports submitted into evidence that Petitioner was

making progress after the first accident. After conservative treatment consisting of being off work for seven months, sixty-five physical therapy sessions, including work conditioning, and an epidural injection, Petitioner was able to return to full duty work. The improvement in his low back condition was negated by the second accident.

In the absence of medical evidence showing the October 21, 2013, accident was not a contributing factor to Petitioner's condition of ill being, the Arbitrator concludes the necessity of the proposed surgery is attributable to the October 21, 2013 accident which clearly changed the character of Petitioner's back complaints and condition.

The Arbitrator concludes Petitioner's request for authorization of the proposed surgery due to the August 7, 2012, accident is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK HARKIN,

Petitioner,

vs. NO: 13 WC 37350

15IWCC0619

GURTZ ELECTRIC & LEND LEASE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent Lend Lease herein and notice given to all parties, the Commission, after considering the issues of causation and prospective medical and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission agrees with the Arbitrator's findings with regard to causation, noting the Petitioner's back pain had significantly improved following his August 7, 2012 accident (the subject of consolidated case number 13 WC 17347), and despite some level of ongoing pain, he continued to work his regular duty job until the October 21, 2013 accident which is the subject of the case at bar. We agree that the October 21, 2013 accident changed the character of Petitioner's

15IWCC0619

back complaints and condition. However, we modify the Arbitrator's decision and find that the Petitioner is entitled to prospective medical treatment.

Following his review of a November 12, 2013 lumbar MRI, Dr. Nolden noted a right-sided focal disc herniation at L5/S1 resulting in displacement of the right S1 nerve root, and that this correlated with Petitioner's predominantly right-sided low back pain which radiated to the right buttock and leg. The Petitioner noted he had undergone conservative treatment in the past, but nevertheless had ongoing pain. As such, Dr. Nolden discussed definitive treatment in the form of L5/S1 discectomy surgery. (Px2A).

Dr. Zelby then examined Petitioner pursuant to Section 12 of the Act, at Respondent's request. He reviewed the lumbar MRI and determined that the films reflected a right-sided L5/S1 herniation, and that this correlated with Petitioner's subjective complaints. (Rx5). Thus, both the treating surgeon and the examining surgeon's comments demonstrate that this recommended surgery is reasonable.

Based upon the above, we find that Petitioner is entitled to the lumbar surgery recommended by Dr. Nolden, that said surgery is related to the October 21, 2013 accident that is the basis of this claim, and that Respondent shall authorize same.

Because future benefits have been awarded in this case, but no specific monetary amounts have been awarded, we have determined that the bond required of Respondent, should this matter be appealed to the Circuit Court, shall be the minimum $100.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator, filed July 28, 2014, is modified to award prospective medical treatment as indicated above, and is otherwise hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

15IWCC0619

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

DATED: AUG 1 2 2015
TJT: pvc
O 06/16/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
8(a)

HARKIN, PATRICK
Employee/Petitioner

Case# 13WC017347
13WC037350

GURTZ ELECTRIC COMPANY
Employer/Respondent

15IWCC0619

On 7/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0579 FRIEDMAN AND SOLMOR
GARY B FRIEDMAN
200 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

0532 HOLECEK & ASSOCIATES
STUART PELLISH
161 N CLARK ST SUITE 800
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1739 STONE & JOHNSON CHARTERED
PATRICK DUFFY
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CHICAGO, IL 60602

15IWCC0619

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
8(a)

Patrick Harkin
Employee/Petitioner

v.

Consolidated cases #: **13 WC 17347; 13 WC 37350**

Gurtz Electric 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 **Jessica A. Hegarty**, Arbitrator of the Commission, in the city of **Chicago**, on **May 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accidents, **8-7-12; 10-21-13,** Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being *is* causally related to the accident of October 21, 2013.

In the year preceding the injury, Petitioner earned $**86,987.68**; the average weekly wage was $**1,672.84**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **0** dependent children.

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

ORDER

Petitioner's current condition of ill being to his lower back is related to the October 21, 2013 accident. Respondent in Claim 13 WC 037350, the October 21, 2013, accident is hereby ordered to authorize the proposed lumbar surgery at L5-S1.

13 WC 017347, the August 7, 2012 accident, petitioner's request for an order directing Respondent to authorize the proposed lumbar surgery at L5-S1 is hereby denied.

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

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

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

Signature of Arbitrator

7/24/14
Date

ICArbDec19(b)

JUL 28 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

PATRICK HARKIN,

Petitioner,

v.

GURTZ ELECTRIC COMPANY

Respondent.

15IWCC0619

No.: 13 WC 17347 ; 13 WC 37350

FINDINGS OF FACT

Petitioner was involved in two accidents while working for Respondent. Respondent is insured by two separate workers compensation carriers for each accident. The sole issue at bar is which carrier is responsible for the prescribed surgery. Neither carrier raises an issue as to the necessity of such surgery.

13 WC 17347

Petitioner is an electrician, employed by the Respondent since October 15, 2004.

On August 7, 2012, Petitioner was lifting a heavy reel of cable onto a jack. He lost his footing, causing him to slip and fall. He injured his right shoulder and elbow, his left knee and his lower back. Petitioner testified that immediately following the accident, he felt intense pain in his lower back and pain in his right leg.

Petitioner testified that for the ten years preceding August 7, 2012, he had no accidents, treatment or problems with his lower back.

Petitioner came under the care of Dr. Scott Cordes who provided treatment from August 9, 2012, to August 27, 2013. Petitioner testified that when he began treating with Dr. Cordes he could hardly walk or stand due to his lower back pain.

Petitioner underwent several surgeries following and related to the August 2, 2012, accident. The surgeries involved his right shoulder, right elbow and left knee. The parties concur that the above mentioned surgeries are unrelated to the matter before the Arbitrator.

An August 20, 2012, MRI of Petitioner's lumbar spine revealed:

a mild disk bulge and a superimposed small right paracentral disk protrusion at L5-S1 resulting in mild dorsal displacement of the descending right S1 nerve root. (PX2)

On September 26, 2012, Dr. Mehta noted that Petitioner presented with lower back pain radiating into the right leg. The doctor noted complaints of numbness and tingling with some weakness in the right leg.

On October 2, 2012, Dr. Mehta administered a steroid injection into the right L5-S1 region of Petitioner's lower back.

Between March 2, 2013 and August 19, 2013, Petitioner participated in physical therapy. Between July 24 and August 19, 2013, the physical therapy included work conditioning.

In the August 12, 2013, work conditioning progress note, the therapist noted that medium level work may be appropriate for Petitioner and that Petitioner was uncertain if he could perform the necessary stair climbing, lifting, and carrying. At the last physical therapy/work conditioning session on August 19, 2013, the therapist documented that Petitioner's back was sore following the last work conditioning session. The therapist recommended additional work conditioning. (RX 3.)

Petitioner testified that he underwent an FCE, but no FCE was contained in Athletico's or Dr. Cordes' records. (PX 5, PX 1.) Petitioner returned to Dr. Cordes on August 20, 2013 and reported that work conditioning aggravated his back. Dr. Cordes permitted Petitioner to return to work with a 20 pound lifting limit. (RX 1.)

On August 27, 2013 Petitioner returned to Dr. Cordes and advised that light duty was not available, and that he did not want to return to work conditioning. Dr. Cordes released Petitioner to full duty on August 27, 2013. (RX 1.)

Petitioner was off work pursuant to Dr. Cordes' orders from January 13, 2013 through August 27, 2013.

Petitioner testified that after participating in sixty-five hours of physical therapy his lower back pain improved.

On August 29, 2013, Petitioner returned to work. He described his duties as installing conduit which required working on a ladder and working overhead. He continued to have pain in his lower back radiating into the right leg. Petitioner testified that he returned to work because Dr. Cordes told him there was no effective treatment that he could provide. (RX 1.)

Petitioner continued working full time, full duty, for nearly two months.

On October 21, 2013, Petitioner suffered a second accident. Petitioner was standing on a scissor-jack and jumped into the air to avoid stepping on a nail. Petitioner testified he felt severe pain in his low back that radiated down his right leg into the right ankle. For the first few days, it was difficult for Petitioner to straighten up or walk. Petitioner went to Concentra on October 21 and October 23, 2013. The physician at Concentra on October 23 ordered light duty and referred him to an orthopedist.

On November 6, 2013, Petitioner presented to Dr. Nolden who noted low back, right hip, groin, and posterior thigh pain. Petitioner told Dr. Nolden that he initially injured his low back with right radiating symptoms in August of 2012. Petitioner assessed his symptoms as 70% alleviated when he returned to "light duty". Petitioner assessed his pain as ranging between 3/10 and 5/10. He also complained of constant right hip pain and intermittent right groin pain. Dr. Nolden ordered an MRI of the lumbar spine. (RX 4.)

On November 12, 2013, Petitioner underwent a lumbar MRI.

On November 13, 2013, Petitioner returned to Dr. Nolden to review the MRI. Dr. Nolden indicated the MRI showed a herniated disc at L5-S1 resulting in dorsal displacement of the right S1 nerve root. The doctor also indicated that the herniation was missed by the radiologist. Dr. Nolden recommended a minimally invasive microdiscectomy at L5 – S1.

Petitioner testified he currently takes anti-inflammatories for pain.

Petitioner testified that he wants the surgery recommended by Dr. Nolan.

Petitioner was examined by Dr. Zelby at the request of the Respondents in 13 WC 37350 on January 15, 2014. Petitioner provided a consistent history of both accidents. Dr. Zelby reviewed and compared the two MRIs of the lumbar spine. Both MRIs showed a herniated L5-S1 disc on the right, consistent with his symptoms. Dr. Zelby agreed that surgery was appropriate. (RX 5.) A Utilization Review report concurred that surgery was reasonable and necessary. The UR report did not include a review of the medical records prior to October 21, 2013. (PX 4A.)

Petitioner testified that he can walk and drive although after sitting or walking for a certain amount of time his pain increases. The light/restricted duty work is difficult for him because he is in a lot of pain.

Petitioner testified that he thinks his low back pain increased following the October 21, 2013 accident.

CONCLUSIONS OF LAW

The fact that Petitioner was experiencing pain and discomfort both prior to and when he returned to work is not surprising. He had not worked for a year following the first accident. The fact he noticed pain while undergoing work conditioning is also not surprising. Petitioner was being pushed by the therapist to perform activities to mimic work activities that he had not performed in nearly a year.

The pain and discomfort verbalized by Petitioner upon his return to work is viewed as an indication he might have suffered permanent residuals to his back from the August, 2012. It is not dispositive of which carrier is responsible for the prescribed lumbar surgery.

The Arbitrator notes that surgery was never recommended with respect to the first accident. None of the treating physicians nor the examiner, Dr. Zelby, render any medical opinion finding the necessity of the surgery was due to the first accident. The Arbitrator cannot overlook the absence of such opinion from Dr. Zelby. If the necessity for the surgery was due to the August, 2012, accident, as the carrier for the October 21, 2013 contends, it would have been expected Dr. Zelby would have opined the October 21, 2013 accident was a temporary aggravation of L5-S1 disc pathology but that the recommended surgery was solely attributable to the earlier August 2012 accident. Dr. Zelby makes no such statement.

When he examined Petitioner, Dr. Zelby took a history. His January 15, 2014 report noted comments of Petitioner that the October 21, 2013, accident occurred, brought an increase in his low back pain and right leg pain to the same severity following the first accident.

Dr. Zelby's report notes that the November 12, 2013, MRI shows mild progression of the degenerative disc disease, most notably at L5-S1. Dr. Zelby also noted Dr. Nolden's November 13, 2013 note, where Dr. Nolden indicated that the most recent MRI showed a herniated disc at L5-S1 resulting in dorsal displacement of the right S1 nerve root.

The Arbitrator notes the prescription for surgery did not occur until after the October 21, 2013, accident. There is no evidence in the record that surgery was recommended with respect to the first accident.

Dr. Nolden's November 13, 2013, progress note indicates Petitioner was seen on November 6, 2013, for diffuse low back pain with radiation into the buttocks, right hip, right groin and posterior thigh after being involved in a work injury on October 21, 2013.

The Arbitrator concludes, based on the Petitioner's testimony and her review of all medical records and reports submitted into evidence that Petitioner was

making progress after the first accident. After conservative treatment consisting of being off work for seven months, sixty-five physical therapy sessions, including work conditioning, and an epidural injection, Petitioner was able to return to full duty work. The improvement in his low back condition was negated by the second accident.

In the absence of medical evidence showing the October 21, 2013, accident was not a contributing factor to Petitioner's condition of ill being, the Arbitrator concludes the necessity of the proposed surgery is attributable to the October 21, 2013 accident which clearly changed the character of Petitioner's back complaints and condition.

The Arbitrator concludes Petitioner's request for authorization of the proposed surgery due to the August 7, 2012, accident is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALLEN KILLEBREW,

Petitioner,

vs.

NO: 11 WC 44044

15IWCC0620

DYNEGY MIDWEST GENERATION,

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 notice, causation, medical expenses, temporary total disability (TTD) and permanency, 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 does, however, wish to clarify that the Arbitrator's granting of Petitioner's motion to amend the Application for Adjustment to add the left hand as an injured body part, in addition to the previously named right hand, was proper. The Respondent objected to this amendment. (Tr. 6).

Section 8(j) of the Act reads, in part, as follows:

"In the event the injured employee received benefits, including medical, surgical or hospital benefits under any group plan covering non-occupational disabilities contributed 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. In such event, the period of time for giving notice of

accidental injury and filing application for adjustment of claim does not commence to run until the termination of such payments. . . ."

Respondent in this case, per the Request for Hearing form (Arbitrator's Exhibit 1), claimed a $26,135.62 salary continuation credit pursuant to Section 8(j). Petitioner's Exhibit 6 indicates that Blue Cross/Blue Shield of Illinois paid medical benefits with regard to treatment received that has been found related to this claim for services between April 7, 2011 and September 25, 2012. Respondent submitted two exhibits in support of its claim for Section 8(j) credit. Respondent's Exhibit 1 is the same as Petitioner's Exhibit 6, and Respondent's Exhibit 2 indicates that the salary continuation benefits were paid to Petitioner from February 2012 through July 2012.

Given that the Respondent specifically requested an 8(j) credit for non-occupational benefits paid, we find it difficult to reconcile that request with its objection to the Petitioner's amendment of the Application for Adjustment of Claim. Section 8(j) clearly tolls both the requirement of notice as well as the statute of limitations, and it is equally clear that the amendment of this Application does not violate the statute of limitations. As the Respondent's requested 8(j) credit includes payments made for left carpal tunnel treatment, we fail to see how the Respondent could have been prejudiced by the amendment of the Application for Adjustment of Claim.

The Commission further wishes to clarify the $26,135.62 Section 8(j) credit granted to Respondent for salary continuation benefits. The Arbitrator awarded 6 weeks of TTD benefits subsequent to each of Petitioner's carpal tunnel surgeries, which took place February 8, 2012 and May 9, 2012. By our calculations, the applicable TTD periods would be from February 8, 2012 through March 20, 2012 (2012 was a leap year and included February 29, 2012), and from May 9, 2012 through June 19, 2012. Respondent is only entitled to a Section 8(j) credit for the salary continuation benefits that were paid to Petitioner during these awarded TTD periods. Respondent is not entitled to a Section 8(j) credit for any salary continuation benefits paid to Petitioner outside of the above listed TTD periods.

The Arbitrator awarded the reasonable, necessary and causally related medical charges incurred for the treatment provided to the bilateral hands for the carpal tunnel conditions, pursuant to Sections 8(a) and 8.2 of the Act, but did not award any charges associated with the treatment Petitioner received to the bilateral thumbs. Respondent was awarded a Section 8(j) credit totaling $30,911.31 for group medical payments made by Blue Cross/Blue Shield. Again, we wish to clarify that Respondent is only entitled to a Section 8(j) credit for those group medical payments that are applicable to the medical bills awarded by the Arbitrator.

The point of these clarifications is to make it clear that, while the Arbitrator awarded specific credits to Respondent pursuant to Section 8(j) of the Act, such credits are not to be taken against the permanency award the Arbitrator granted to Petitioner. It is also to make clear that,

15IWCC0620

based upon the application of these credits, the bond in this matter will be based solely upon the permanency award.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on April 4, 2014 is hereby affirmed and adopted, with clarification as noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $669.64 per week for a period of 51.25 weeks, as provided in Section 8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 12.5% of the left hand and 12.5% of the right hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,066.67 per week for a period of 12 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable, necessary and causally related medical charges incurred for the treatment provided to the bilateral hands for Petitioner's carpal tunnel conditions, pursuant to Sections 8(a) and 8.2 of the Act, and that Respondent shall not be responsible for any charges associated with the treatment Petitioner received to the bilateral thumbs.

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 $34,400.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 12 2015
TJT: pvc
O 06/22/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KILLEBREW, ALLEN
Employee/Petitioner

Case# **11WC044044**

DYNEGY MIDWEST GENERATION INC
Employer/Respondent

15IWCC0620

On 4/4/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0368 WIMMER & STIEHL
WILLIAM L WIMMER
2 PARK PL
SWANSEA, IL 62226

0299 KEEFE & DePAULI PC
NEIL GIFFHORN
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0620

STATE OF ILLINOIS)
)SS.
COUNTY OF WILLIAMSON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ALLEN KILLEBREW
Employee/Petitioner

v.

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

Case # 11 WC 44044

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 **Brandon J. Zanotti**, Arbitrator of the Commission, in the city of **Herrin**, on **January 17, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 3, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$83,200.00**; the average weekly wage was **$1,600.00**.

On the date of accident, Petitioner was **56** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$26,135.62** for salary continuation, for a total credit of **$26,135.62**.

Respondent is entitled to a credit of **$30,911.31** under Section 8(j) of the Act.

ORDER

Respondent shall pay for the reasonable, necessary, and causally related medical charges incurred for the treatment provided to the bilateral hands for the carpal tunnel conditions, pursuant to Sections 8(a) and 8.2 of the Act. However, Respondent shall not be responsible for any charges associated with the treatment Petitioner received to the bilateral thumbs.

Petitioner is awarded 12 weeks of temporary total disability benefits at the rate of $1,066.67/week for the recovery from his bilateral carpal tunnel releases, pursuant to Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64/week for 51.25 weeks, because the injuries sustained caused the 12.5% loss of use to each hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

03/17/2014
Date

APR 4- 2014

15IWCC0620

STATE OF ILLINOIS)
) SS
COUNTY OF WILLIAMSON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

ALLEN KILLEBREW
Employee/Petitioner

v. Case # 11 WC 44044

DYNEGY MIDWEST GENERATION, INC.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner, Allen Killebrew, was hired by Respondent, Dynegy Midwest Generation, Inc., in May 2002, and for the vast majority of that time worked as a Journeyman Maintenance Technician. He testified that this job required him to work on coal crushers, pumps, valves, conveyors, and scrubbers. These activities often required the use of hand tools, and also small impact wrenches, air ratchets, various grinders, and jack hammers.

On March 3, 2011, Petitioner presented to his family doctor, Dr. Duk Kim, who ordered electrodiagnostic testing. (Petitioner's Exhibit (PX) 5). Petitioner stated at trial that he complained to Dr. Kim of having problems for a while with dropping things, having pain and numbness, and he perceived it to be work-related at this point. Bilateral upper extremity nerve conduction studies on April 7, 2011 showed right carpal tunnel syndrome, but no abnormalities on the left. (PX 4). On April 29, 2011, Dr. Kim referred Petitioner to Dr. Harvey Mirly for a surgical consultation. (PX 5).

Dr. Mirly first saw Petitioner on December 20, 2011, and diagnosed him with bilateral carpal tunnel syndrome as well as severe CMC arthritis of the bilateral thumb MP joints. (PX 1). An operative report dated February 8, 2012 outlines Dr. Mirly's surgery for left carpal tunnel release for the wrist and in the left thumb the excision of trapezium, ligament reconstruction, tendon interposition, and volar metacarpophalangeal capsulodesis. A nearly identical procedure was done to the right upper extremity and thumb on May 9, 2012. (PX 1; PX 2). Following these procedures, on September 25, 2012, Petitioner was placed at maximum medical improvement and noted to have previously been released to full unrestricted duty. (PX 2).

Dr. Mirly was asked a hypothetical regarding Petitioner's job duties with Respondent which included a list of tools purported to be used and alleged that the jobs required substantial or repeated use of the hands and exposure to vibration from hand tools. (PX 3, pp. 17-18). Dr. Mirly gave a causation opinion in Petitioner's favor based upon this hypothetical. (PX 3, p. 19). Dr. Mirly believed Petitioner's thumb conditions were aggravated by his job duties (PX 3, pp. 19-23), but Petitioner testified at trial that he was seeking no benefits for his bilateral thumb conditions. Dr. Mirly testified that he would have released Petitioner to full duty work six

weeks after each carpal tunnel release. Dr. Mirly went on to say that Petitioner was off work for a longer period of time due to the thumb condition and related surgeries. (PX 3, pp. 38-39).

On October 22, 2013, Petitioner was evaluated by Dr. William Strecker at Respondent's request pursuant to Section 12 of the Illinois Workers' Compensation Act, 820 ILCS 305/1 *et seq.* (hereafter the "Act"). Dr. Strecker opined that Petitioner's job duties with Respondent were a contributing factor to his bilateral carpal tunnel syndrome and need for treatment. Dr. Strecker found no evidence that Petitioner's job duties caused, aggravated or accelerated Petitioner's thumb conditions. (PX 9).

Petitioner testified that since returning to work for Respondent, he has not had much difficulty with his bilateral hands/wrists. If a job becomes too hand intensive, he may experience some difficulties. If he performs a job that requires a lot of pulling or impact, his fingers will swell the following day. He does not experience much numbness or loss of hand strength.

CONCLUSIONS OF LAW

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

Issue (D): What is the date of accident?;

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

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

Petitioner was diagnosed by Dr. Kim on March 3, 2011 with right carpal tunnel syndrome. The left carpal tunnel syndrome was diagnosed by Dr. Mirly on December 20, 2011. Dr. Mirly testified that it was his opinion that Petitioner had bilateral carpal tunnel syndrome that was work-related. Dr. Strecker, Respondent's examining physician, confirmed this diagnosis and its causal relationship to Petitioner's job duties with Respondent. Petitioner testified that he was not seeking benefits for his bilateral thumb conditions.

Based on the foregoing, the Arbitrator finds that Petitioner suffered bilateral carpal tunnel syndrome that arose out of and in the course of his employment, and that said condition is causally related to his work duties with Respondent. Petitioner also alleged that he gave oral notice to Respondent concerning his injuries. No evidence was presented to the contrary, and therefore proper notice was given. Further, March 3, 2011 is an appropriate manifestation date of Petitioner's injuries.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Petitioner underwent treatment for bilateral carpal tunnel syndrome, including surgical releases by Dr. Mirly. The charges incurred for the treatment of the carpal tunnel syndrome are found to be reasonable and necessary, but on Petitioner's admission that the bilateral thumb conditions are not work related, those corresponding charges are denied as compensable under the Act. The parties stipulated to the fact that Respondent is entitled to a credit under Section 8(j) of the Act for $30,911.31 in medical benefits paid on behalf of Respondent's group health carrier.

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

Dr. Mirly testified that he treated the non-compensable bilateral thumb conditions at the same time as the compensable bilateral carpal tunnel syndromes. It was the testimony of Dr. Mirly that he would have released Petitioner to full duty six weeks after each carpal tunnel release. Dr. Mirly went on to say that Petitioner was off work for a longer period of time due to the thumb surgeries. Because of Petitioner's admissions and the holdings listed above, temporary total disability benefits in the amount of 12 weeks are appropriate and awarded. The parties stipulated to the fact that Respondent paid Petitioner $26,135.62 in salary continuation for which Respondent is awarded a credit toward the temporary total disability award.

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

Petitioner underwent bilateral carpal tunnel releases and was returned to full duty work. Since returning to work for Respondent, Petitioner has not had much difficulty with his bilateral hands/wrists. If a job becomes overly hand intensive, Petitioner may experience some difficulties. If he performs a job that requires considerable pulling or impact, his fingers will swell the following day. Petitioner does not experience much numbness or loss of hand strength.

Based upon the foregoing, the Arbitrator finds that Petitioner experienced the 12.5% loss of use of the right hand and 12.5% loss of use of the left hand, pursuant to Section 8(e) of the Act.

Issue (O): Was Petitioner's Motion to Amend the Application of Adjustment of Claim at trial appropriate?

At trial, Petitioner moved to amend his Application for Adjustment of Claim to include the left hand. The original Application only listed the right hand as the body part involved. Respondent objected. Under the Relation Back Doctrine, if the original complaint had sufficient information for Respondent to prepare a defense there is no harm in amending the complaint. *Ill. Inst. of Technology Research Inst. v. Industrial Comm'n*, 314 Ill. App. 3d 149, 731 N.E.2d 795 (1st Dist. 2000); *see also Fizer v. Related Management, Co.*, 12 IWCC 330 (March 28, 2012). Herein, Respondent knew Petitioner was claiming benefits originally for right carpal tunnel syndrome and was able to prepare and defend for bilateral hand complaints since the medical records clearly showed both hands underwent surgery. Petitioner's Motion to Amend the Application was appropriate and is allowed.

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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KATHY PARADIES,

Petitioner,

vs.

NO: 09 WC 22683

15IWCC0621

STATE FARM INSURANCE,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical expenses, temporary total disability (TTD) and permanency, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment with Respondent on April 20, 2009. Based on this finding, all other issues are moot.

The Commission believes that the totality of the evidence in the record indicates that the Petitioner did not strike her head on a revolving security door in the course of her employment on April 20, 2009.

Video of the alleged accident of April 20, 2009 was submitted as Respondent Exhibit 17. Photos from the video were submitted by Petitioner as her Exhibits 23 and 24. We find the video of the alleged accident to be significant in this case. While it is clear that the film is choppy, and there are seconds in between frames which are not visible, we nevertheless see no evidence whatsoever of a head trauma. The video shows no evidence of panic, pain, grimacing or impact

in the Petitioner, either while she still remained in the doors, or after she exited them. Instead, she appears to walk out of the revolving door normally, like nothing unusual occurred. She stops and waits for her husband to exit the revolving door. At no time did she reach up to touch the area of her head that she said was impacted, or give any other visible indicia of a head impact. The Petitioner verified that the video was of her and was taken at the time of the alleged incident. While the Arbitrator felt that Petitioner stopped at one point and her head went up, this appears to have occurred several seconds prior to when the door reversed forward again and Petitioner claims she was struck. Additionally, the testimony of Zach Moore notes that when the door stops, a light appears at the top of the door, and that Petitioner may have lifted her head at that point due to the light appearing.

We do not rely solely upon the video. We also find, based on the testimony and the medical evidence in the record, that issues exist with regard to the Petitioner's credibility.

Petitioner's medical records from April 7, 2009 and preceding (Rx1) note chronic left ear pain, sinus infections for over a year, and an acute worsening over the two prior weeks. The report noted Petitioner's statement that she often waits too long to seek treatment for sinus infections, and that she hoped she had made the visit soon enough so that she could get adequate treatment. The April 22, 2009 records of Dr. Gill (Px9) verify recent difficulties with a middle ear infection. Petitioner agreed that she was "tired" when she arrived at work on April 20, 2009. She appeared to the Commission to be evasive on cross examination in answering questions about the patient history noted in Dr. Ingalsbe's April 20, 2009 report. (Tr. 42-47). The report indicates the Petitioner was dizzy when she arrived at work that day, and that Petitioner was stressed due to an incident involving her daughter the night before and was tearful on her way to work, and "just was not quite right as far as getting around". Petitioner's complaints were that her dizziness was a little bit worse after striking her head, the hearing in her left ear was slightly muted and she felt like she was leaning to the left. An examination of her scalp was negative. Dr. Ingalsbe's diagnosis was: "Vertigo, probable benign position vertigo exacerbated some by a very mild head trauma."

Respondent's Exhibit 21 purports to be an accident report regarding Petitioner's alleged April 20, 2009 injury, submitted by her husband, Louis Paradies. His statement indicated that Petitioner was entering the revolving door from the garage area into the cafeteria when it reversed itself. Petitioner was trying to go backwards with the door, and when it again reversed to go forwards again, that she hit the back of her head. When he made it through the door behind her, Mr. Paradies stated that Petitioner said she was dizzy and couldn't walk on her own without falling to her left. (Rx21). We see no evidence of such difficulty in the video when the Petitioner and her husband were walking away from the revolving door.

Petitioner testified that the door struck her in the left rear of her head. (Tr. 48-49). Petitioner testified on May 14, 2013 in fairly significant detail in terms of how the door reversed, that she then backed up, and hit her head when it went forward again. (Tr. 10-15). She testified about speaking to Respondent's insurance representative Tracee Topping within a week after the

accident and telling her she heard the sound of the door and didn't remember anything after that, but did remember the door striking her. (Tr. 10-15).

In her April 28, 2009 recorded statement to Ms. Topping, Petitioner stated that she didn't recall what occurred, other than that she was returning with her husband from lunch, and that when the door began to reverse she had a feeling of panic, "and I have pretty much no memory after that" (Respondent's Exhibit 26, p. 4). She further stated that: "it's very frustrating not to be able to remember something that you were told that happened to you, you know?" (p. 13-14). She essentially indicated that, due to her memory problems, her knowledge of what occurred came from her husband. (Rx26, p. 5-6).

Louis Paradies also spoke to Ms. Topping on April 28, 2009, stating that Petitioner was in the revolving door, and he was behind her waiting to enter, when it reversed direction and started to go backwards. (Rx26). He could not remember if he heard a recorded voice warning or not. While there usually was a warning, he also noted the door usually backs the person out of the doors as well. It didn't do that this time, instead, he stated, a second or two later it again reversed and again moved forward. He indicated this is when Petitioner was struck in the back of her head, and that it "whopped her in the head pretty good". (Rx26, p. 17). It is unclear to the Commission why Mr. Paradies, given Petitioner's alleged memory problems, his witnessing of the alleged incident and his significant involvement in providing the history of the alleged incident to both Respondent and various medical providers, did not testify at hearing. In particular, we note that none of his statements prior to the hearing date were made under oath.

Various diagrams and other information regarding the revolving security door Petitioner walked through were submitted as Respondent's Exhibit 18. Zach Moore, a Respondent security specialist, testified in this case as well. We find the testimony of Zach Moore, Respondent's safety security specialist, to be credible with regard to both the workings of the revolving security door at issue, as well as how it was highly unlikely that Petitioner struck her head based on the video evidence. Mr. Moore testified that he was responsible for the door at issue, and that he obtained the videotape of the alleged accident for the hearing. He explained how the door worked, that the door did not malfunction on April 20, 2009, but rather did what it was supposed to do. It moves slowly, glides and does not jerk, and he testified that this is exactly what was depicted in the video. He testified that even if there were an impact, the force behind the door is negligible and causes no harm. He also noted there was a significant amount of room in each door quadrant, so it was not a tight space, and he described how Petitioner's positioning within that space made it virtually impossible for her to have suffered a head trauma as she described. His review of the video indicated that the front of Petitioner's head was closer to a door panel than the back of her head. This is supported by the videotape. He testified that, other than Petitioner, no one else had claimed that the door struck them and/or caused an injury.

As noted, Dr. Ingalsbe's initial examination of Petitioner's head reflected no evidence of scalp injury. (Px3). April 21, 2009 brain CT scan and EEG testing were both within normal limits, as was an April 22, 2009 EEG. It should be noted that Dr. Ingalsbe's January 14, 2009

records (Rx1), which predate the alleged accident, also reflect that an emotionally volatile child recently came to live with Petitioner and her husband, and that she was stressed. She was diagnosed at that point with adjustment disorder. Petitioner reported having some depression, and indicated she was in counseling.

Even Dr. Hurley, Petitioner's main treating physician in 2010, testified that, after reviewing the video evidence of the alleged incident, it was not consistent with Petitioner's history, noting he did not see a trauma to the back of the head happening, and if anything it looked like the door would have struck the front of her head, not the back. (Px1, pp. 15-16).

Neuropsychologist Dr. Kurth evaluated Petitioner on October 8, 2009. (Px21). He determined that his evaluation was difficult to interpret, noting that most findings were out of proportion to the biomechanics of her alleged injury and to the acute clinical presentation. Additionally, he opined that the delayed onset of retrograde and anterograde amnesia and a number of the specific presenting complaints of Petitioner were unusual for an organic etiology, as was the time frame for symptom development. (Px21). Dr. Kurth further opined that Petitioner was at risk for developing an entrenched self-concept of disablement.

The Commission notes the June, 2009 report and April, 2010 testimony of Dr. Soriano, Respondent's Section 12 examiner, with significant interest. A neurosurgeon, Dr. Soriano diagnosed Petitioner with hysterical conversion reaction with significant functional illness and symptom exaggeration, with no signs of post-concussion syndrome. (Rx12).

The Commission believes that a full review of the medical records before and right after the alleged April 20, 2009 accident reflects a significant similarity of complaints. While the Petitioner alleged that her pre-accident symptoms worsened due to the head trauma, we believe that it is much more likely that there was no real head trauma, and that the Petitioner, as opined to by Dr. Kurth and Dr. Soriano, developed a conversion reaction or adjustment disorder of some sort, possibly triggered by the incident she had with her daughter the night before and the ongoing personal problems in this regard she had both before and after April 20, 2009. Dr. Kurth indicated Petitioner very likely suffered a mild concussion, but that the constellation of cognitive symptoms she reported were likely unrelated to the physiologic injury, but rather appeared to be a function of her emotional reaction to several significant life stressors which had developed in a short time. The Commission, as noted above, does not believe that the Petitioner sustained the trauma she claims she had, and that the opinion of Dr. Kurth regarding a mild concussion is primarily based on Petitioner's stated history of head trauma.

The Commission notes that, while the Petitioner has requested temporary total disability benefits through August 20, 2010 due to problems, at least in part, with reading (both on paper or on the computer), the April 30, 2010 report of Dr. Pepper noted Petitioner had returned to school (Px11), and the July 21, 2010 report of Dr. Ingalsbe indicates that Petitioner had been studying for school, and was preparing for finals. This indicates to the Commission that the Petitioner had been in school for some time prior to August 20, 2010, and apparently was able to study and

complete her coursework, while also being held off work. While it is certainly possible that eight hours of sustained work could have been more difficult for Petitioner than handling schoolwork, the complete record leads us to believe that the Petitioner was capable of performing more work than she subjectively indicated, further damaging her credibility in this case.

The Petitioner has subjective complaints about her vision. Objective testing has shown no abnormalities to support these complaints. Petitioner has complained of dizziness and headaches. Objective testing has shown nothing to support these complaints. While the medical evidence in the case indicates that objective testing of the head and brain can be negative despite a concussion, we also note that these complaints, along with left sided sinus issues, predated the alleged accident. Taking everything together, while it is possible that the Petitioner had a head trauma as she claims, we believe the preponderance of the evidence supports the finding that such trauma did not occur. Instead, it appears to indicate that the Petitioner was suffering with some preexisting physical and emotional issues, and that Petitioner's belief that the alleged accident has caused a worsening of her condition has resulted in a conversion reaction or adjustment disorder. Ultimately, our determination is that the Petitioner failed to prove that she sustained an accidental injury arising out of and in the course of her employment. Taking all of the evidence in the record together, we find it significantly more likely that the Petitioner developed a psychological conversion reaction than that she sustained an impact to her head from the revolving door. Our review of the videotape indicates no evidence whatsoever of a head trauma. We note the Petitioner's preexisting issues with headaches, left ear infection and sinus problems, as well as a stressful situation with her daughter. We believe the Petitioner lacks credibility with regard to her complaints, in particular her alleged memory issues, and we believe that a fair reading of all the medical evidence in the record indicates that the vast majority of opinions finding a causal relationship of Petitioner's subjective complaints to the alleged accident are significantly based on the veracity of Petitioner's history of the incident. Because we believe the greater weight of the evidence indicates a head trauma did not take place, we give these opinions little weight. The vast majority of the numerous physicians involved in this matter had some level of questioning of Petitioner's various and longstanding subjective complaints.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed as noted above, to find that Petitioner failed to prove that she sustained accidental injuries arising out of and in the course of her employment with Respondent on April 20, 2009.

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.

15IWCC0621

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

DATED: AUG 12 2015
TJT: pvc
O 06/22/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

STATE OF ILLINOIS)	☐ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☒ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL JURICH,

Petitioner,

15IWCC0622

vs. NO: 12 WC 015912

CENTRAL LIFT MAINTENANCE,

Respondent.

DECISION AND OPINION ON REVIEW

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

The Decision of the Arbitrator awarded Petitioner 10% loss of use of man as a whole to compensate Petitioner for the injury to his left hand and the resultant diminution in his earning capacity. The Commission modifies the award, finding compensation is more appropriately merited under Section 8(e) of the Act than under Section 8(d)2, finding Petitioner exaggerated the extent to which he was injured and to the extent the injury prevented him from realizing his pre-accident income. Some of Petitioner's exaggerations are more egregious than others, but they have the cumulative effect of diminishing Petitioner's credibility.

Before Arbitrator Mason, Petitioner repeatedly provided testimony concerning his treatment that is simply not found in his medical records. He testified Dr. Schiappa, a Holy Cross Hospital-affiliated physician, on April 26, 2012, replaced the Holy Cross Hospital-provided splints on his left thumb and left index finger with new ones due his thumb and index finger being so swollen that it made the original splints too tight. Dr. Schiappa's examination record of the visit made no reference to either of Petitioner's digits being swollen and indicated that only

Petitioner's thumb was placed in a splint. He further testified to Dr. Schiappa providing him with a sling on May 2, 2012, that he was to keep his left arm in due to unremitting swelling of the same. Dr. Schiappa's May 2, 2012, note made no mention of Petitioner's left arm being swollen during that visit or of Petitioner complaining that it was swollen any day prior. Dr. Wiedrich succeeded Dr. Schiappa as Petitioner's treating physician and, similarly, his as-testified-to-history concerning treatment with Dr. Wiedrich are not reflected in Dr. Wiedrich's records. He testified that Dr. Wiedrich, on March 23, 2012, ordered him to undergo occupational therapy for his index finger. The Commission notes that, on that date, Dr. Wiedrich wrote, "At this point the index finger needs no additional treatment except observation." He also testified to complaining to Dr. Wiedrich of excruciating pain on July 2, 2012, pain attributed to his left thumbnail growing into his skin. Dr. Wiedrich's noted on July 2, 2012, only that Petitioner may be experiencing "some residual tenderness over the tip of the thumb," an indication that Dr. Wiedrich did not appreciate Petitioner being in excruciating pain on that day. The above examples of how Petitioner's testimony differs from his medical records gives the Commission reason to believe that he was less than forthright when relating his medical history to Arbitrator Mason.

In finding Petitioner to be less disabled than Arbitrator Mason, the Commission also finds Petitioner suffered neither an injury that partially incapacitated him from pursing his usual and customary line of employment nor anything but a self-induced impairment of earnings. Petitioner was a crane technician/mechanic before his injury and returned to the same after being released to return to work. Petitioner provided no testimony to being unable to perform his duties, only to having those duties cause exacerbations of his claimed symptoms. He testified to needing assistance from another journeyman and an apprentice to perform his job activities but provided no witnesses to testify to this occurring. For these reasons, the Commission finds that a showing of incapacitation is absent. The Commission also finds no evidence of an impairment of earnings that wasn't self-induced. Petitioner's testimony is the only evidence that he is unable to work the mandatory overtime to his injury. His treating physicians' records did not limit the number of hours he could work. The Commission does recognize that Petitioner's hourly wages decreased due to his losing of the shift differential but also finds Petitioner failed to provide any explanation as to why he remained working the first shift rather than resume working the second shift and benefit from the shift differential pay rate. No medical record was found that precluded Petitioner from doing so.

As noted above, the Commission finds compensation for Petitioner's injuries to be more appropriately awarded under Section 8(e) of the Act. Given the injuries sustained to Petitioner's hand, the Commission deems an award of 30% loss of use the left hand to be just compensation, noting that the left hand is Petitioner's non-dominant hand but that the injury has left Petitioner with diminished grip strength in two fingers and a claim of increased pain in those fingers during cold weather.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $695.78 per week for a period of 61.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 30% loss of use of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

15IWCC0622

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 $42,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 1 2 2015
KWL/mav
O: 06/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0622

JURICH, MICHAEL
Employee/Petitioner

Case# **12WC015912**

CENTRAL LIFT MAINTENANCE GROUP
Employer/Respondent

On 10/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0009 ANESI OZMON RODIN NOVAK KOHEN
JOHN POPELKA
161 N CLARK ST 21ST FL
CHICAGO, IL 60601

1153 MARTIN, PATRICK W
203 N LASALLE ST
SUITE 2100
CHICAGO, IL 60601

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

15IWCC0622

Michael Jurich
Employee/Petitioner

v.

Central Lift Maintenance Group
Employer/Respondent

Case # **12** WC **15912**

Consolidated cases: **D/N/A**

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **9/25/14**. By stipulation, the parties agree:

On the date of accident, **4/24/12**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**78,000.00**, and the average weekly wage was $**1,500.00**.

At the time of injury, Petitioner was **39** years of age, ***married*** with **0** dependent children.

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

Respondent shall be given a credit of $**3,797.92** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**3,797.92**.

15IWCC0622

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

ORDER

Respondent shall pay Petitioner the sum of $**695.78**/week for a further period of **50** weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused **10% loss of use of man as a whole.**

Respondent shall pay Petitioner compensation that has accrued from **4/24/12** through **the date the decision becomes final**, and shall pay the remainder of the award, if any, in weekly payments.

Insert appropriate order text here. You may use and modify the appropriate text from the list of boilerplate paragraphs at http://www.iwcc.il.gov/arbordertext.doc

To modify the form, go to Review/Protect document/Restrict formatting/Stop protection/password = iwcc (lower case)

If you want to re-protect the document, in order to tab through fields and have the drop-down menus work, click on "Editing restrictions" and you will be prompted to enter the password. You don't have to enter the password. Click "ok."

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

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

Molly C Mason
Signature of Arbitrator

10/20/14
Date

OCT 20 2014

15IWCC0622

Michael Jurich v. Central Lift Maintenance Group
12 WC 15912

Summary of Dispute

The sole issue in dispute is nature and extent. The parties agree that Petitioner, a union crane mechanic, accidentally hit his non-dominant left hand with a sledgehammer on April 24, 2012. They disagree as to the precise nature of the injury and its effect. Petitioner seeks a permanency award under Section 8(d)2 based, in part, on a diminution of earnings theory while Respondent maintains that permanency should be awarded under Section 8(e) and only for injuries to the left thumb and left index finger.

Arbitrator's Findings of Fact

Petitioner, a Local 150 member, testified he has been classified as a Class A journeyman crane mechanic for nine years. T. 12. He began working as a crane mechanic for Respondent about 6 ½ years before his accident of April 24, 2012. T. 11. As of the accident, he worked second shift, earning $35.60 per hour (including a $.50/hour shift differential). As of the hearing, he was working the first shift, earning $36.15 per hour. T. 13.

Petitioner testified that, before the accident, his regular work schedule consisted of 48 hours per week, including Saturdays. He typically worked 15 to 18 hours of overtime per week in addition to the 48 hours. T. 14.

Wage records produced by Respondent (PX 5) reflect gross earnings of $101,919.05 for the 52 weeks preceding the accident. T. 14-15. Petitioner disagreed with the figures in PX 5. He testified he earned between $140,000 and $150,000 per year, on average, during the 6 ½ years he worked for Respondent before the accident. T. 15.

Petitioner testified his job duties for Respondent included maintaining heavy equipment such as Gantry cranes and side loaders. A Gantry crane is used to move and stack railroad boxes. It is 65 feet tall and spans over 170 feet. T. 15-16.

Petitioner testified he is required to lift a maximum of 350 to 400 pounds on his own. The items that weigh in this range include steel cylinders and saddles. Petitioner testified he is required to put a cylinder on his shoulder and carry it up a 12-foot ladder to put it into a spreader. T. 18. A "saddle" is welded out of steel and used, along with a hydraulic press, to push out pins that might be stuck or caught. A pin in a Gantry crane weighs between 150 and 175 pounds. T. 21.

Petitioner testified that "not much" of his work is performed at ground level. In addition to ladders, he uses aerial man baskets and lifts to access cranes. A man basket can lift him to a height of 85 feet. T. 19.

Petitioner testified he is 5 feet, 10 inches tall. He weighed 220 pounds as of the accident. He weighs 260 pounds now. He is right-handed. T. 22.

Petitioner testified he was working at a CSX railroad facility on April 24, 2012. He was in a man basket, about 65 feet in the air, using a 15-pound sledgehammer to hit a chisel and wedge while trying to split apart a pre-cut nylon roller so that he could access a pin. T. 24-25. His view of his work area was limited because he was leaning over another wedge that was underneath his stomach, supporting another roller. As he was swinging the sledge hammer, that roller suddenly moved, causing him to hit his left hand with the sledge hammer. He felt an immediate onset of excruciating pain in his left hand and began sweating. He knees buckled and he believes he fainted. When he came to, he was still in excruciating pain. In order to get back down to the ground, he had to kneel and use his affected left hand to hold down the "dead man" floor pedal while operating the controls with his right hand. T. 27. He was eventually able to gain control over the man basket and get down to the ground. He was unable to walk. As he started crawling toward the office, another worker came to his aid and called 911. He was taken by ambulance to Holy Cross Hospital.

The Emergency Room records set forth a consistent history of the work accident. They reflect that Petitioner complained of pain and numbness in his left thumb and left index finger and pain in his left middle finger. They also reflect that Petitioner's left thumb was "blue and swollen." On examination, the Emergency Room physician, Dr. Eggebeen, noted "left hand swelling with ecchymosis of left thumb nail, swelling and TTP [tenderness to palpation] of left thumb, left index and left middle finger." He described capillary refill as normal. A nurse drained a subungual hematoma of the left thumb. The doctor ordered left hand X-rays. He interpreted the films as showing a tuft fracture of the left thumb and a fracture of the middle phalanx of the second digit. PX 1, p. 22. A final X-ray report documents a cortical fracture at the end of the distal phalanx of the left thumb with minimal separation. PX 1, p. 25. A technician applied splints to the left thumb and left index finger. PX 1, p. 22.

When Petitioner was discharged from the Emergency Room, he was given prescriptions for Keflex and Hydrocodone and was told to avoid using his left hand for three days and see Dr. Schiappa in the hospital's cast room early the next morning. PX 1, pp. 22-23, 29, 31.

Petitioner testified he opted for ice applications rather than pain medication at the Emergency Room because he was concerned that narcotic pain medication could adversely affect another non-work-related health condition. T. 45-46.

On April 26, 2012, Dr. Schiappa dictated a note indicating he had seen Petitioner the previous day in follow-up from the Emergency Room. He described Petitioner as sustaining "injury to the left hand involving all 3 digits 1, 2 and 3." He indicated he provided splinting and advised Petitioner to stay off work for two weeks and start exercising the second and third digits. PX 2, p. 15.

Petitioner testified that Dr. Schiappa changed the splints on his left thumb and left index finger on April 25, 2012 because those digits had swollen so much the original splints could not withstand the pressure. T. 30.

Petitioner returned to Dr. Schiappa on May 2, 2012. Repeat left hand X-rays taken that day again showed "evidence of avulsed cortical fracture of the distal portion of the distal phalanx of the left thumb" with "no interval change in alignment." PX 2, p. 16. Dr. Schiappa placed Petitioner's left arm in a sling "for elevation of the extremity." He advised Petitioner to stay off work and follow up on May 15, 2012. PX 2, p. 13.

Petitioner testified Dr. Schiappa put his left arm in a splint and instructed him to keep the arm elevated because "the swelling wouldn't go down." T. 31.

On May 22, 2013, Dr. Schiappa dictated the following note:

> "The patient was originally seen on 5/15/12 at the office. He had visited the Emergency Room on 4/24/12 with follow-up at the outpatient department on 4/25/12. The patient has sustained injury to the left hand involving all 3 digits first, second and third. Today, X-rays reveal no change. Very sensitive area over the palm. Range of motion restricted on the palm due to pain. The patient not able to work. The patient was advised to return in 2 weeks. The prescription of Vicodin 5/325 mg was given. The patient is to return in 2 weeks."

PX 2, p. 14.

Petitioner testified he decided to change physicians after seeing Dr. Schiappa on May 15, 2012 because he was felt he was not getting proper care and wanted another opinion. T. 31. He decided to see Dr. Wiedrich, a hand surgeon affiliated with Northwestern. T. 31.

Dr. Wiedrich's initial note of May 23, 2012 reflects that Petitioner primarily complained of his left thumb and left index finger secondary to a crushing injury of April 24, 2012. The note also reflects that Petitioner "was diagnosed with left thumb and index finger fractures" and had not yet returned to work.

Dr. Wiedrich indicated that Petitioner complained of pain in his left thumb and left index finger along with numbness on the tip of his thumb. On examination, the doctor noted the following:

> "The patient has evidence of a crushing injury to the left thumb and index finger. Sensation is 7 mm both borders of each digit to the index and thumb. He has 20 degrees of IP flexion. He has a new fingernail growing underneath

> the old nail. There is an exposed nail bed. There is tenderness over the area of the distal phalanx of the thumb. He has no tenderness down the length of the index finger. He has digital range of motion to the index and small fingers."

Dr. Wiedrich obtained X-rays. He interpreted the films as showing a distal tuft fracture of the left thumb, no evidence of fracture or dislocation in the left index finger, no arthritis and no mass. PX 3, p. 14.

Dr. Wiedrich placed Petitioner's left thumb into a tip protector with a dry dressing to avoid nail avulsion. He prescribed range of motion exercises. He indicated that, "at this point, the index finger needs no additional treatment except observation." He instructed Petitioner to return in two weeks. He released Petitioner to restricted work with no use of the left hand. PX 3, pp. 5-7, 13.

Petitioner underwent an initial occupational therapy evaluation the same day, May 23, 2012. The therapist noted that Petitioner reported "inability/difficulty with buttons-pants, grasping door knob, opening car door." The therapist noted a pain rating of 6/10 and "moderate edema to LD1 at P1 and IP joint." She provided Petitioner with a custom-designed left thumb tip protector. PX 3.

Petitioner testified he returned to work on May 25, 2012. At that point, he was experiencing a lot of pain and sensitivity in his thumb and "first" finger. His "second" finger was "very sensitive to the touch." T. 33. He was technically supposed to work only in the office but Respondent "kept pulling [him] out of the office and having [him] work on the crane pad because they didn't have enough mechanics to do the job." T. 33. For one particular job, he had to use both hands to hold twist locks while other workers were reconnecting the twist lock cylinder. T. 34.

Petitioner returned to Dr. Wiedrich on June 7, 2012, with the doctor noting a complaint of pain at the tip of the left thumb. The doctor also noted that Petitioner indicated he "returned to work and his one-handed restrictions were not adhered to."

On re-examination, Dr. Wiedrich noted no swelling about the left thumb, tenderness over the tip and a good range of motion. He obtained new X-rays which he interpreted as showing "evidence of fracture without healing." PX 3, p. 21. He continued the previous work restrictions and recommended desensitization and strengthening exercises. He instructed Petitioner to return in three weeks. PX 3, pp. 15-16, 20.

Petitioner attended an occupational therapy session the same day, June 7, 2012. The therapist described Petitioner as presenting "with orthosis in place and reports of significant sensitivity to temperature." She instructed Petitioner in various desensitization exercises using objects such as cotton balls, lentils, beans and rice. She provided Petitioner with a

desensitization wand and home exercises. She noted that Petitioner was "reluctant to subject thumb to tapping and some textures secondary to discomfort."

Petitioner testified that, as of June 7, 2012, he was experiencing excruciating pain in his "tips," especially the tips of his thumb and index finger. He found it very difficult to grip or squeeze anything. T. 35.

Petitioner next saw Dr. Wiedrich on July 2, 2012. In his note of that date, the doctor described Petitioner as "here for a follow-up evaluation after an injury to his left thumb." He noted that Petitioner reported improvement but was still complaining of tenderness as well as a sensation of "something moving underneath the skin." He noted that a new left thumbnail was coming in "with some irregularity." He also noted mild tenderness over the ulnar aspect of the distal phalanx of the left thumb, a palpable scar and a good range of motion. He released Petitioner to full duty as of July 17, 2012 and instructed Petitioner to call him after two weeks of full duty. He indicated Petitioner would likely be at maximum medical improvement at that point. He also indicated that Petitioner "may have a permanent nail deformity and there may be some residual tenderness over the tip of the thumb." PX 3, pp. 22-23.

Petitioner also attended occupational therapy on July 2, 2012. The therapist noted a pain rating of 0/10 and an "improved ability to open a car door, button, tie shoes, turn doorknob," etc. She indicated Petitioner was still having difficulty opening water bottles and manipulating nuts, bolts and tools for prolonged periods. She noted that minimal edema was still visually evident. She performed Jamar dynamometer grip strength testing, noting a mean of 126.67 in the unaffected right hand versus 105 (+18.34) in the affected left hand. She also performed Jamar dynamometer pinch strength testing, noting lateral, 3-point and 2-point results of 27, 23.5 and 20 pounds on the right versus 25 (+21), 19 (+14.5) and 14 (+8.5) on the left. She indicated that Petitioner demonstrated "improved thumb mobility, sensation and strength in left thumb" but would "continue to work on desensitization on his own." She discharged Petitioner from therapy due to "maximum therapeutic benefits achieved." PX 3, pp. 24-26.

Petitioner testified that, as of July 2, 2012, his left thumbnail was growing back but it was growing into the skin rather than up. The nail was also still split. The nail area was excruciatingly painful. It felt as if he had an ingrown nail that was growing back. T. 36.

Petitioner testified he opted to take two weeks of vacation time rather than resume full duty on July 17, 2012. He used his vacation time because he felt as if he was not ready to resume his regular tasks. T. 37. When he returned from vacation, he resumed full duty. He found it a "lot harder" to perform his regular tasks. He relied on another worker, either a journeyman or an apprentice, to complete a lot of jobs. T. 37-38. When he had to squeeze something between his thumb and first finger, he would experience "bone on bone action" and shooting pains through his hand. He would have to immediately let go of whatever he had been holding. The shooting pain would last all day and sometimes as many as two to three days before subsiding. T. 38.

Petitioner returned to Dr. Wiedrich on August 20, 2012, with the doctor now describing him as being seen for "evaluation of his left thumb/index finger injury." Dr. Wiedrich noted that Petitioner complained of occasional left index finger numbness with repetitive activity and persistent pain in the tip of his left thumb, "worse with direct pressure, change of weather and gripping tools."

On left thumb examination, Dr. Wiedrich noted tenderness to palpation over the volar aspect of the distal phalanx, extension of 20 degrees and flexion of 65 degrees. On left index finger examination, he noted a full range of motion and "normal TTP." He found Petitioner to have reached maximum medical improvement. He indicated there was nothing more he could do to address Petitioner's complaints of pain and numbness. He indicated that Petitioner "will likely have difficulty with cold weather for at least the next few years." PX 3, pp. 28-29. He again released Petitioner to full duty. PX 3, p. 30.

Petitioner testified he continued performing hand exercises at home after discontinuing formal care. He still performs these exercises daily, before and after work. T. 39.

At the request of his attorney, Petitioner underwent an examination by Dr. Coe on May 18, 2013. Dr. Coe is a board certified occupational medicine physician. PX 4.

Dr. Coe's detailed history reflects that Petitioner "noted immediate pain in his left first, second and third fingers" as well as swelling and bruising of the left thumbnail following the April 24, 2012 work accident.

Dr. Coe indicated he reviewed the initial Emergency Room records along with the records of Drs. Schiappa and Wiedrich.

Dr. Coe indicated that Petitioner complained of numbness at the tip of his left thumb, left thumb stiffness and "tightness" and left index finger stiffness. He also indicated that Petitioner reported having difficulty using tools and performing forceful gripping secondary to these complaints. He further noted that Petitioner described his symptoms as increasing with cold exposure.

On examination, Dr. Coe noted evident deformity of the left thumbnail consistent with the subungual hematoma, nail loss and regrowth, tenderness over the radial, volar and ulnar aspects of the left thumb distal phalange, mild tenderness over the left index finger, second and distal phalanges. He also noted reduced motion of the proximal interphalangeal joint of the left index finger. He noted 110 degrees of motion on the right versus 90 on the left, with normal being 110 degrees. He described sensation of both thumbs and index fingers as grossly intact and symmetrical to light touch. He described both hands as warm to touch. He noted no abnormal sweating or coloration.

Dr. Coe measured Petitioner's pinch grip strength at 32 pounds on the right versus 18 on the left. He indicated that left pinch grip strength testing was associated with complaints of left thumb distal phalange pain and "popping." He indicated he was unable to perform full grip strength Jamar dynamometer testing "due to complaints of left hand pain and evident difficulty in handle gripping of the dynamometer." At position 2, he noted 100 pounds on the right versus 60 on the left. At position 4, he noted 90 pounds on the right versus 50 on the left.

Dr. Coe summarized Petitioner's injuries as follows: "Mr. Jurich suffered a contusion of his left hand, thumb and index finger in an accident at work on April 24, 2012. The injury caused a fracture of the distal phalange (tuft) of the left thumb with associated soft tissue contusion, as well as soft tissue contusion, tendinitis and synovitis in the left index finger."

Based on his examination findings, Dr. Coe found that the work accident caused permanent partial disability to Petitioner's left hand. PX 4.

At Respondent's request, Petitioner saw Dr. Atluri for purposes of a Section 12 examination on April 10, 2014. Dr. Atluri is a board certified orthopedic surgeon and fellowship-trained hand surgeon affiliated with Hand to Shoulder Associates. RX 2.

Dr. Atluri's report of April 30, 2014 sets forth a detailed and consistent account of the work accident of April 24, 2012. The doctor noted that Petitioner described striking his left thumb, index and middle fingers with a hammer "very forcefully."

Dr. Atluri described Petitioner's complaints as follows:

> "Currently, the patient states that his left hand has ongoing problems. He states the left index finger tends to flex. He states that his left thumb tends to 'stick out.' He states that he feels tingling from the tip of his thumb to the tip of his index finger. He states that his left index finger gets stiff. He reports pain in his left index finger extending into the first dorsal web space and pain extending from his thumb into his wrist. He reports by the end of the day, his thumb and index finger 'want to touch.' He states that the two digits tend to drift towards each other throughout the day. He states that he feels 'grinding against my skin' in his thumb. He reports increased pain when subjected to cold temperatures."

Dr. Atluri noted that Petitioner denied any prior left hand problems.

Dr. Atluri indicated that Petitioner was "currently working at his regular job with the assistance of an apprentice." He further noted that Petitioner's work activities "routinely involve forceful and heavy use of his upper extremities including awkward positioning and use of hand tools."

On examination, Dr. Atluri noted:

-no intrinsic atrophy of the left hand
-full active flexion of the fingers
-slight extension lag in the middle finger with active extension
-minus about 10 degrees at the PIP joint
-0.5 cm of thumb opposition to the fifth metacarpal head actively
-some scars along the radial and ulnar aspect of the distal phalanx of the thumb, secondary to the reported injury
-an abnormality in the thumb nail plate "with a little bit of splitting along the ulnar aspect of the nail plate"
-no tenderness over the A-1 pulley of any digits
-palpable triggering of the left index finger
-no triggering in any of the other digits
-no intrinsic or extrinsic tightness in the fingers
-full passive extension of the fingers
-normal skin color, hair growth and sweat pattern
-positive Tinel's over the carpal tunnel
-positive digital compression test over the carpal tunnel
-negative Tinel's over the dorsal radial sensory and dorsal cutaneous ulnar nerves
-left wrist extension of about 40 degrees and flexion of 80 degrees
-tenderness along the distal phalanx of the thumb but not in the index or middle fingers
-no palpable masses in the thumb
-two point discrimination greater than 8 mm in the radial and ulnar aspects of the thumb
-two point discrimination of about 8 mm at the radial aspect of the index finger and less than 8 mm in all other fields

Dr. Atluri described Petitioner as "cooperative throughout the exam." He noted no inconsistencies.

Dr. Atluri obtained X-rays of the left hand and wrist. He indicated these X-rays showed "ulnar negative variance," a healed fracture of the distal phalanx of the left thumb with a little bit of a volar and ulnar prominence near the tip of the distal phalanx, no fractures in either the index or middle fingers and no signs of osteomyelitis.

Dr. Atluri indicated he reviewed the occupational therapy notes as well as Dr. Wiedrich's records.

Dr. Atluri's impression was: 1) crush injury left thumb with distal phalanx fracture, healed; and 2) crush injury, left index finger.

Dr. Atluri found Petitioner to have reached maximum medical improvement.

Dr. Atluri proceeded to perform a formal AMA impairment rating. He indicated he performed a diagnosis-based rating for the thumb and index finger. He described the "most relevant" diagnosis for the left thumb as a distal phalanx fracture. He viewed an alternative "range of motion impairment rating" to be inappropriate "due to the lack of significant motion loss." He found that Petitioner qualified for a Class 1 level of digit impairment due to the presence of residual symptoms, consistent objective findings with normal motion. He reached a final thumb digit impairment rating of 6% (converting to a hand impairment rating of 2%) based on various grade modifiers, including Petitioner's "Quick-Dash" score of 59.1, the moderate palpatory findings on examination and the thumb X-ray results (i.e., a "healed fracture with a slight residual deformity"). With respect to the left index finger, Dr. Atluri noted that he used a diagnosis of "pain in the digit" because he was not able to detect any mechanical abnormalities in the finger. He indicated that Petitioner's "history of painful injury with residual symptoms that are not supported by consistent objective findings" qualified him for a Class 1 level of impairment. Using various grade modifiers, including the "Quick-Dash" results, the "minimal palpatory findings" and the left index finger X-ray results, he arrived at a grade modifier of 0. He then applied the "net adjustment formula" to reach a final digit impairment of 1% of the index finger. He indicated that, based on Table 15-12, that "allows conversion to a hand impairment value of 0%." He arrived at a total hand impairment of 2% after adding the two finger impairment values together at the hand level. Citing Table 15-11, he indicated that the 2% hand impairment "allows conversion to a final upper extremity impairment value of 2%." RX 1.

Petitioner testified he is still a member of Local 150. He continues to work as a crane mechanic for Respondent. The nature of his duties has not changed but his job has changed in the sense that "the overtime is different" and the workload has increased due to two other mechanics being off work secondary to injuries. T. 50. He has lost overtime earnings because he tries to take Saturdays and Sundays off to rest his hand so that he can "make it through Monday through Friday." He applies "Icy Hot" to his hand at night. He applies ice packs when his hand swells. He performs a lot of hand exercises. T. 41.

Petitioner identified PX 6 as his 2011 W2 form. This form reflects earnings of $112,427 for 2011, the last full year he worked before the accident. T. 43. Petitioner identified PX 7 as a paycheck stub dated September 5, 2014 reflecting total gross earnings of $63,797.62 to date for the year 2014. Petitioner testified that, based on PX 7, he would be on track to earn about $85,000 to $87,000 as of the end of 2014. He attributed the diminution of earnings to his injury and the resultant loss of overtime. He is not declining overtime simply in order to work less. As a result of losing overtime earnings, he has lost his house and a grocery store business he used to operate. T. 44.

Petitioner testified he uses his thumb very cautiously. When he has to grip an object, he feels a "bone on bone" reaction, as if something is grinding inside the thumb. His thumbnail is

very sensitive. He continues to lift 300- to 350-pound objects but with difficulty. He has to use big wrenches and he finds it difficult to twist and turn them. He has to "constantly take breaks" and shake his hand out to increase circulation. It is common for him to drop tools. He did not have this problem before the accident. When he uses both hands to swing a sledgehammer, his left hand sometimes just "lets go," causing him to lose control of the hammer. T. 48-49. His left hand grip strength is reduced. When he tries to squeeze something, he has to "let go right away." T. 49. When the temperature starts to drop, his fingertips hurt and he feels as if he cannot get his hand to warm up. T. 49-50.

Petitioner testified he anticipates that his workload will increase still further because three of his fellow mechanics are retiring as of January 1, 2015 and one of the injured mechanics will not be returning to work. These four individuals will be replaced by two apprentices who will require supervision and training. The apprentices will "not know what they are doing" so he will have to perform the work as he is teaching them. T. 51.

Under cross-examination, Petitioner acknowledged sustaining minor scrapes or cuts to his left hand before the accident but denied undergoing any left hand treatment before the accident. T. 53. He was employed as a journeyman crane mechanic before the accident and is still so employed. T. 53. As of the accident, he earned $35.60 per hour. He now earns $36.15 per hour. T. 54. He is performing the same work he performed before the accident. T. 54. No doctor has imposed work restrictions or instructed him to avoid working overtime. T. 54-55. He did not undergo surgery in connection with the accident. T. 56. His thumb, index finger and middle finger were placed in separate splints at the Emergency Room. He wore these splints until the following day. T. 56. His primary injury was to the tip of his left thumb. T. 57. He also injured the center of his left index finger due to squeezing a chisel. T. 57. He underwent treatment for the middle finger but only in the Emergency Room. T. 58. The Emergency Room doctor told him there was a hairline fracture in the tip of the index finger. T. 59-60. Dr. Wiedrich did not treat only his thumb. Dr. Wiedrich treated his thumb, index finger and middle finger. T. 62. Dr. Wiedrich discussed a possible thumb surgery with him but did not recommend it. Dr. Wiedrich explained that he would have to insert a pin in the thumb and the pin would likely come out due to the nature of Petitioner's work. T. 63. Dr. Wiedrich treated his left index finger via therapy. T. 63. The therapy focused on all three fingers. T. 64. He attended four or five therapy sessions. T. 64. He also did home therapy. T. 65. He is not sure why Dr. Wiedrich's note of June 7, 2012 mentions only the thumb because he complained of all three fingers. T. 67. He has nail deformities in his left thumb and his left middle finger. T. 69. His condition has stayed the same since he last saw Dr. Wiedrich in August 2012. T. 72. His symptoms worsen in cold weather. T. 73. He completed "Quick Dash" reports concerning both of his hands when he saw Dr. Wiedrich on July 12, 2012. He had no problems using his right hand to open a jar as of that date. T. 74. When he saw Dr. Atluri, he refused to complete a "Quick Dash" because the doctor would not tell him if it pertained to his right hand or his injured left hand. He called his attorney from Dr. Atluri's office. He asked the doctor to clarify which hand he was referring to but the doctor refused. T. 79-81. Dr. Atluri spent over 90 minutes with him. T. 81. His Saturday hours are mandatory but he can relinquish those hours to another worker. If no other worker bids on those hours, he has to work them himself. T. 81.

He gives up his Saturday hours in order to prepare himself for Monday. T. 82. He has to teach apprentices what to do by actually doing the work in front of the apprentices. The apprentices do not attend school. T. 83.

On redirect, Petitioner testified he has three years to go before he is fully vested, pension-wise. If he were already fully vested, he would not be working his current job because the job causes hand pain. He would try to do something different. T. 84. Because of the air conditioning in the hearing room, his left hand is currently freezing. The cold takes a big toll on him in terms of his comfort level. He declined to complete some forms at Dr. Atluri's office because no one provided those forms to his attorney beforehand, as his attorney requested. T. 88.

Under re-cross, Petitioner testified he can make a fist with his left hand. He can move the fingers of his left hand. He can also move his left thumb but not the tip. It is painful for him to move his thumb up and down. He can move his index and middle fingers but they are stiff and numb. This is why he does exercises. T. 91.

No witnesses testified on behalf of Respondent.

Arbitrator's Credibility Assessment

Petitioner came across as a hard-working individual who knows his trade inside and out. The Arbitrator found his testimony concerning the mechanism of injury, his duties and his ongoing complaints to be highly credible. The Arbitrator observed that, throughout the hearing, Petitioner held his left hand in an unusual, flexed fashion. Petitioner's left index finger consistently jutted upward.

What is the nature and extent of the injury?

Because Petitioner's undisputed work accident occurred after September 1, 2011, the Arbitrator assesses permanency pursuant to Section 8.2 of the Act. As a preliminary matter, however, the Arbitrator considers the underlying dispute as to the extent and effect of the injury. As to the extent, the Arbitrator considers Petitioner's testimony that, after the initial insult, he was required to use his affected left hand to depress a "dead man" pedal in order to bring himself down to ground level. It is clear from Petitioner's testimony that he normally would have used his foot and body weight to depress this pedal.

At the outset, the Arbitrator notes a discrepancy between the records of the Emergency Room and Dr. Schiappa and those of Dr. Wiedrich. The former are more in line with Petitioner's testimony in that they document injuries to three rather than two digits. Dr. Wiedrich's earliest records focus on one digit, the left thumb, but his last note mentions the left index finger as well.

The most detailed record in evidence, in terms of findings, is the lengthy examination report authored by Dr. Atluri, Respondent's examiner. Dr. Atluri made objective findings on left hand and wrist examination that no other physician did. For example, he documented left index finger triggering, slight extension lag in the middle finger with active extension and positive Tinel's and digital compression testing over the carpal tunnel. Although he used only certain thumb and left index finger examination findings in conducting his AMA impairment rating, he at no point suggested that the other abnormalities, i.e., the triggering, etc., were unrelated to the work accident. His finding as to triggering of the left index finger is consistent with the Arbitrator's observation and Petitioner's testimony as to his left index finger not lying flat. The doctor's positive Tinel's findings are consistent with Petitioner's testimony that he routinely drops tools.

While the Arbitrator has considered Dr. Atluri's AMA rating, she has also given consideration to the doctor's other objective findings, which did not play a role in that rating.

The Arbitrator finds that the accident of April 24, 2012 did not affect merely two digits, as Respondent contends, but rather Petitioner's overall left hand function and thus his ability to perform his trade. It is that finding, along with Petitioner's compelling testimony as to his reduced earnings and diminished ability to perform his duties, that prompt the Arbitrator to assess permanency under Section 8(d)2 rather than 8(e) of the Act. It has long been held that Section 8(e) is not the exclusive remedy for all scheduled injuries. Springfield Park District v. Industrial Commission, 49 Ill.2d 67, 72 (1971). The often-quoted language of Section 8(e) ["shall not receive any compensation under any other provisions of this Act"] was intended to prevent double, rather than an entirely separate, recovery. The Appellate Court has held that the quoted language means that, if an injured worker receives an award under 8(e), he is not entitled to any other compensation except temporary total disability. General Electric Co. v. Industrial Commission, 89 Ill.2d 432, 436 (1982). [See also Lusietto v. Industrial Commission, 174 Ill.App.3d 121, 129 (1988), in which the Court emphasized that scheduled losses are not exclusive and that a claimant "may have an option . . which will result in an award more favorable than a schedule award."

In Archer Daniels Midland Co. v. Industrial Commission, 99 Ill.2d 275, 280 (1983), the Supreme Court held that a worker's injuries must be serious and permanent and result in a permanent partial disability or impairment in order for him to be eligible for benefits under Section 8(d)2. That section sets forth three alternative scenarios under which an injured worker may collect benefits. In the instant case, it is the third scenario that applies: "[or] if such injuries partially incapacitate him from pursuing the duties of his usual and customary line of employment but do not result in an impairment of earnings capacity, or having resulted in an impairment of earnings capacity, the employee elects to waive his right to recover" under Section 8(d-1). Petitioner established that his injuries partially incapacitate him from pursuing his usual crane mechanic duties, in that he now has difficulty performing certain tasks and requires assistance from other workers. Petitioner also established that his injuries resulted in an impairment of earnings, not in terms of his hourly wage but in terms of his overall schedule. While no physician has directed Petitioner to reduce or eliminate overtime, the Arbitrator finds

credible Petitioner's testimony that he routinely offers his overtime hours to other workers so as to be able to get through a five-day work week.

In assessing permanency, the Arbitrator also considers Petitioner's relatively young age. Petitioner was 42 years old as of the hearing. He could potentially work for many more years. He credibly testified he plans to give up his union trade in about three years, when he vests, due to his injury.

The Arbitrator also considers that, while the injury involves Petitioner's non-dominant hand, his work requires him to use both hands to turn heavy wrenches, swing 15-pound sledgehammers and lift and maneuver very heavy items. He must also use both hands while working in confined "man lifts" at substantial heights.

Based on all of the foregoing, the Arbitrator awards permanency equivalent to 10% loss of use of the person, or 50 weeks of benefits, under Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Roman Sobolyev,
Petitioner,
vs.
Yellow Transportation,
Respondent,

15IWCC0623

NO: 08WC 43283

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner, herein and notice given to all parties, the Commission, after considering the issues of temporary total disability, permanent partial disability, penalties, vocational rehabilitation, 8(d)1, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 31, 2014, is hereby affirmed and adopted.

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

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

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

DATED: AUG 13 2015
MJB/bm
o-08/10/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SOBOLYEV, ROMAN
Employee/Petitioner

Case# **08WC043283**

15IWCC0623

YELLOW TRANSPORTATION
Employer/Respondent

On 10/31/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0312 BOUDREAU NISIVACO LLC
ALAN R BOUDREAU
120 N LASALLE ST SUITE 1250
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
JASON D KOLECKE
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF **COOK**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Roman Sobolyev
Employee/Petitioner

v.

Yellow Transportation
Employer/Respondent

Case # **08** WC **43283**

Consolidated cases: _____

15IWCC0623

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **9/9/14 & 9/10/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☒ What temporary benefits are in dispute?
☒ TPD ☒ Maintenance ☒ TTD
L. ☒ What is the nature and extent of the injury?
M. ☒ Should penalties or fees be imposed upon Respondent?
N. ☐ Is Respondent due any credit?
O. ☒ Other **Entitlement to vocational rehabilitation and benefits under Sec. 8(d)(1)**

FINDINGS
On the date of accident, **7-17-08**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**52,484.64**; the average weekly wage was $**1,009.32**.

On the date of accident, Petitioner was **36** 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 $**50,201.69** for TTD, $**2,143.99** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**52,345.68**.

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

ORDER
Credits
Respondent shall be given a credit of $**50,201.69** for TTD, $**2,143.99** for TPD, and $**0** for maintenance benefits, for a total credit of $**52,345.68**.

Medical benefits
Respondent shall pay reasonable and necessary medical services of $**330.00**, as provided in Sections 8(a) and 8.2 of the Act.

Temporary Partial Disability
Respondent shall pay Petitioner temporary partial disability benefits of $**454.20**/week for **12-1/7** weeks, commencing **9/12/08** through **12/5/08**, as provided in Section 8(a) of the Act.

Temporary Total Disability
Respondent shall pay Petitioner temporary total disability benefits of $**672.88**/week for **77** weeks, commencing **7/18/08** through **9/11/08 and 12/6/08** through **3/26/10**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**50,201.69** for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of $**605.92**/week for **200** weeks, because the injuries sustained caused the **40%** loss of the **person as a whole**, as provided in Section 8(d)(2) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**605.92**/week for **1.9** weeks, because the injuries sustained caused the **5%** loss of the **right middle finger**, as provided in Section 8(e) of the Act.

In no instance shall this award be a bar to subsequent hearing and determination of an additional amount of medical benefits or compensation for a temporary or permanent disability, if any.
RULES REGARDING APPEALS Unless a party files a *Petition for Review* within 30 days after receipt of this decision, and perfects a review in accordance with the Act and Rules, then this decision shall be entered as the decision of the Commission. **STATEMENT OF INTEREST RATE** If the Commission reviews this award, interest at the rate set forth on the *Notice of Decision of Arbitrator* shall accrue from the date listed below to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

Signature of Arbitrator

10·30·14
Date

ICArbDec19(b)

OCT 31 2014

15IWCC0623

FACTS

History of Case

On July 17, 2008 the petitioner was thirty-six year old male, married with one dependent under the age of eighteen. Petitioner work for the respondent as an over the road truck driver and had an average weekly wage of $1,009.32. It has been stipulated by respondent that the physical job requirements of an over the road truck driver for the respondent are considered heavy to very heavy in nature, with the need to lift up to one hundred pounds as well as pushing or pulling up to one hundred pounds.

While working for the respondent on July 17, 2008, the petitioner sustained an undisputed accident when he slipped and fell on a greasy wet floor. As a result of this accident, the petitioner landed on his right side striking his right middle finger, right shoulder and low back. Proper notice of the accident was provided and petitioner had immediate treatment.

Petitioner's Testimony

Petitioner testified that at the time of hearing he was homeless and living in a van. He had no source of income and had been homeless since December of 2010. He was born in the Ukraine, underwent eight years of education and two years of technical school. After technical school he worked in a factory for two or three years. Petitioner worked as a machinist performing pipe excursion which required him to lift up to 20lbs.

When petitioner turned twenty six years of age he came to the United States. He first lived in Minnesota where he worked construction for two years. Petitioner testified he spoke five languages including, Polish, Ukrainian, Czechoslovakian, English and Russian. He testified that Russian was his primary language. Petitioner testified he moved to Chicago and worked as a taxi driver, limo driver until he obtained his CDL license and became an over the road truck driver.

On January 22, 2004 the petitioner began working for the respondent as an over the road driver. Petitioner testified to a detailed description of his job duties while working for respondent.

Petitioner testified that on July 17, 2008 he was attempting to wipe the windows on his truck when he slipped and fell landing on this right hand, right shoulder and low back.

Petitioner briefly described his initial treatment and the fact that he underwent surgery on September 29, 2009. Petitioner testified that after surgery he found no improvement as compared to prior to surgery.

Petitioner testified that he last saw a doctor in June of 2013 when he saw Dr. DiGianfilippo. He stated Dr. DiGianfilippo discussed additional surgery but he did not want to proceed with additional surgery.

Petitioner testified he contacted Dr. Montella on September 16, 2013 in order to obtain an updated work restriction note.

Petitioner testified in March of 2010 he started searching for a job by using ethnic newspapers. He stated he called almost every ad in those papers.

Petitioner testified that in October of 2010 he moved back to the Ukraine. He lived there until at least December of 2010.

Petitioner provided a job search log detailing the job searches he performed from March of 2010 through the date of hearing. (Pet. Ex #3) These logs consisted of approximately 47 pages of employers and phone numbers. Petitioner testified that he contacted by phone each one of the employers listed.

Despite contacting over three thousand employers, petitioner testified he was not offered a job from anyone listed on the job search logs.

On August 4, 2013 petitioner began working at Larissa's Embroidery in North Carolina. Petitioner testified that he obtained this position through a connection he made via the internet. Petitioner worked there through September 21, 2013. While working there petitioner earned $290.00 per week. (Pet. Ex. # 18)

After petitioner stopped working at Larissa's Embroidery he traveled back to Florida to continue his employment search. Petitioner testified he continued to search the internet for a job up until the time of hearing.

Petitioner testified as to his day to day activities waking up every morning in pain. He took over the counter aspirin. He lived in his van and begged for food or money and was affiliated with homeless shelters. He received $200.00 per month in food stamps. He described having an "Obama phone" which consisted of 250 minutes per month. He became a United States citizen in 2013.

Medical Treatment History for Petitioner's low back condition

Petitioner first began treating for this accident on July 17, 2008 with Dr. Carlito Org. (Pet. Ex #6) He also treated with Dr. Eric Nagaj on the same date. (Pet. Ex #8) At this time petitioner was diagnosed with low back pain, right hand pain and right shoulder pain. An x-ray of petitioner's right hand revealed a fractured right third phalanx. (Pet. Ex #6)

On July 21, 2008 the petitioner underwent an MRI of his lumbar spine. This exam revealed a left paracentral protrusion at L4-L5 and evidence consistent with an annular tear. A slight to moderate bulge was also seen at L5-S1, as well as degenerative findings. (Pet. Ex #11)

Pursuant to Section 12 of that Act the petitioner was examined by Dr. Babak Lami on August 28, 2008. Dr. Lami opined petitioner's low back condition was related to the July 17, 2008 accident. He diagnosed the petitioner with a back strain and recommend physical therapy. He prescribed three to four weeks of physical therapy with work restrictions consisting of no lifting greater than ten pounds and no repetitive bending. (Resp. Ex #3)

Beginning on October 1, 2008 petitioner began treating with Dr. Bruce Montella. (Pet Ex #11) Petitioner provided a consistent history of the accident. Petitioner expressed continued complaints of low back and right hand pain. Dr. Montella interpreted the lumbar spine MRI to show a herniated disc and radiculitis at L4-L5 as well as moderate bulging at L5-S1 and minimal bulging at L3-L4. Dr. Montella prescribed physical therapy, chiropractic treatment and medication. He also restricted petitioner from returning to work in any capacity. (Pet Ex #11)

On November 21, 2008, the petitioner was examined by Dr. Steven Delheimer at the request of respondent pursuant to Section 12 of the Act. Dr. Delheimer was of the opinion the petitioner was unable to work and need to be examined by a spine specialist to determine if surgery was necessary for his condition. (Resp. Ex #4)

After the Section 12 exam with Dr. Delheimer, Petitioner continued to treat with Dr. Montella for his low back condition through the remainder of the 2008 calendar year. During that three month period, petitioner's low back complaints continued to be debilitating pain with radiation into his leg. (Pet. Ex #11)

On February 19, 2009 Dr. Montella recommend possible surgical intervention to relieve his condition. Prior to proceeding, petitioner obtained a second opinion from Dr. Anthony DiGianfilippo.

Petitioner was examined by Dr. DiGianfilippo on March 9, 2009. Based on the petitioner's desire to undergo surgery for his low back condition, Dr. DiGianfilippo prescribed a lumbar myelogram and a lumbar CT scan. (Pet Ex #13)

Petitioner continued with conservative care in an effort to prevent the need for surgery. However, due to continued complaints of low back pain, the petitioner elected to undergo surgery with Dr. Montella. Petitioner underwent surgery on September 29, 2009. The operative procedure consisted of lumbar disc decompression at L5-S1,

lumbar dis compression at L4-L5 as well as lumbar discography at L3-L4, L4-L5 and L5-S1. (Pet Ex #11)

Subsequent surgery petitioner was restricted from working and prescribed physical therapy, chiropractic treatment and pain medication. On January 27, 2010, petitioner was examined by Dr. Montella indicating his symptoms had not significantly changed. Based on this assessment continued physical therapy, chiropractic treatment and pain medication was prescribed. However the medical records indicate that petitioner stopped undergoing physical therapy or chiropractic treatment in December of 2009. (Pet Ex #7 & #8)

On March 19, 2010, petitioner was again examined by Dr. Delheimer at the request of respondent, pursuant to Section 12 of the Act. After reviewing the details of petitioner's entire medical treatment, including the surgical report, diagnostic exams, chiropractic and physical therapy notes as well as performing a physical exam, Dr. Delheimer diagnosed the petitioner with continued spondylolisthesis at L5-S1. It was his opinion that this condition pre-dated the July 17, 2008 accident. Dr. Delheimer was of the opinion petitioner had reached maximum medical improvement and no further treatment was necessary. He also stated that petitioner was not in need of any work restrictions as a result of the July 17, 2008 injury. (Resp. Ex #4)

On April 26, 2010 petitioner provided a history of no significant changes and continued pain radiating down his leg. As a result of these complaints, Dr. Montella recommended petitioner obtain an opinion consisting of an additional surgical consultation for other treatment options. He also recommended a Functional Capacity Exam to determine petitioner's possible need for permanent work restrictions. At this time Dr. Montella continued to restrict the petitioner from working in any capacity. (Pet Ex #11)

Petitioner returned to see Dr. Montella on January 7, 2011. Petitioner indicated that there had been no change in his current condition and he experienced radiating pain down his left leg with numbness and tingling in the back that was constant and debilitating. Dr. Montella indicated that petitioner had 70% impairment and could need additional treatment including, physical therapy, medication and possible surgery. Petitioner was restricted from working for additional two months and instructed to follow up. (Pet Ex #11)

On August 29, 2012, petitioner returned to see Dr. Montella. Petitioner stated his symptoms had worsened since his last visit and he had continued radiating pain. He stated he had difficulty walking, standing or sitting. He was unable to do any lifting and tried to perform a home exercise program. Dr. Montella placed the petitioner at maximum medical improvement. Additional treatment was possibly needed in the future

but nothing was prescribed. No work restrictions were provided at the time of this visit. The petitioner was instructed to return in three months. (Pet Ex #11)

Petitioner never returned to see Dr. Montella, however, he did contact him on September 16, 2013. As a result of this contact, Dr. Montella drafted a note stating petitioner was permanently and totally disabled and he was unable to work in any capacity as of August 29, 2013. (Resp. Ex #7)

Petitioner's Medical Treatment for his Right Middle Finger Condition

Petitioner treated for his middle finger condition at Hand Surgery Associates. (Pet. Ex #12) His first date of treatment at this facility was on February 9, 2009 and March 2, 2009. Petitioner was diagnosed with a middle finger PIP joint sprain. Dr. Vitello opined on March 2, 2009 petitioner's finger condition allowed him to return to unrestricted work and no surgical treatment was need. He was instructed to follow up on a per needed basis.

Dr. Bruce Montella Deposition Testimony

Dr. Bruce Montella testified in conjunction with this hearing on June 24, 2011 and March 19, 2014. (Pet. Ex #14)

During the direct examination of Dr. Montella's testimony on June 24, 2011 he recited the details of petitioner's complaints and the treatment rendered. He testified as to the reasonableness and necessity of petitioner's surgery. (pg. 22-24) Dr. Montella testified that as of January 7, 2011 petitioner had reached MMI. (pg. 27-28) At the time of MMI petitioner was precluded from performing activities of heavy lifting. (pg. 28) He further testified that petitioner's condition was a direct result of the July 17, 2008 accident. (pg. 30) Dr. Montella further testified that the work accident permanently aggravated petitioner's spondylolisthesis. (pg. 41)

On cross examination Dr. Montella testified that the petitioner did benefit from surgery based on the fact that he did not go on to have additional surgery. (pg. 33)

During Dr. Montella's direct testimony on March 19, 2014, he reiterated petitioner reached MMI as of January 7, 2011. (pg. 4) He recited the details of his examination of the petitioner on August 29, 2012. (pg. 6) He confirmed that as of that date, August 29, 2012 he had not provided a work status report of petitioner's physical abilities. (pg. 7) He further testified that he opined the petitioner was permanently and totally disabled as of September 16, 2013 and was incapable of working as a truck driver. (pg. 7-8)

On cross examination, Dr. Montella testified, that petitioner was capable of working in a light duty capacity as of June 24, 2011. (pg.10). He further testified that as of September 16, 2013 the petitioner was permanently and totally disabled from any work. (pg. 10) Dr. Montella testified that he did not examine the petitioner in conjunction with drafting the permanent total disability note. He also admitted to being aware that the petitioner had worked in a light duty capacity prior to the September 16, 2013 note being written. (pg. 12)

Section 12 Examiner -Dr. Steven Delheimer – Deposition Testimony

Dr. Steven Delheimer testified in conjunction with this hearing on February 27, 2013. (Resp. Ex #5)

During direct examination Dr. Delheimer testified that he examined the petitioner on two separate occasions, once on November 21, 2008 and again on March 19, 2010. (pg. 8) Dr. Delheimer testified to the way he conducted his exams and the history the petitioner provided. (pg. 8) He testified that based on his exam of the petitioner on November 21, 2008 petitioner suffered from pre-existing spondylosis as a result of the work accident. (pg. 11) Dr. Montella also testified as to his findings during his March 19, 2010 exam. These findings consisted of excessive pain manifestation, with limping, grunting, grimacing, which Dr. Delheimer stated was not found during the 2008 exam. (pg. 14) He testified his neurological exam was considered normal. (pg. 14) He testified that as of March 19, 2010 the petitioner had reached maximum medical improvement. (pg. 15) Dr. Delheimer also testified that petitioner was capable of returning to work. (pg. 17)

On cross examination Dr. Delheimer testified as to the details of his practice as well as his IME practice. (pg. 19) He testified to his reading of the diagnostic exams and medical records. (pg. 21-22) Dr. Delheimer also testified that he did not believe the accident caused a structural change in the petitioner's low back. (pg. 23) He also testified that petitioner had a positive straight leg exam during the first exam in 2008 and a negative exam in 2010. (pg. 25) He testified that these findings supported his opinion as to petitioner's ability to return to work. (pg. 31)

Vocational Deposition Testimony – Chrisann Schiro-Geist – Petitioner's Expert

Ms. Geist testified in conjunction with this hearing on August 29, 2013. (Resp. Ex 15)

On direct examination Ms. Geist provided her educational as well as her professional background. (pg. 1-15) She testified that she initially interviewed the petitioner on May 26, 2010 at the request of petitioner's attorney. (pg. 16) She testified as to the history of

the petitioner including residency, educational background and employment history. (pg.17) Ms. Geist recited the details she was provided by the petitioner as to his current physical abilities and complaints of pain. (pg. 18-23) She described the "Wide Range Achievement Test" she administered to the petitioner and the results of that test. (pg. 23) She testified to the medical records she reviewed. (pg. 25) She also provided her conclusions subsequent her evaluation. Ms. Geist testified that petitioner could be an interpreter or work a technical job. (pg. 26) She also testified as to a second report she drafted on August 15, 2013 at the request of petitioner's attorney. (pg. 27) She testified as to her review of the job logs sent to her reflecting petitioner's job search as well as the details of petitioner obtained job in embroidery. (pg. 28) Ms. Geist was of the opinion that petitioner's job search was adequate and the embroidery position was an appropriate position for the petitioner. (pg. 29) She testified that she did not believe the petitioner could physically return to his previous position as a truck driver. (pg. 32)

On cross examination, Ms. Geist testified she was unsure as to whether petitioner's education in metallurgy was a transferrable skill to positions in the United States. (pg. 38) She testified that petitioner's ability to speak three separate languages would benefit him in new employment opportunities. (pg. 40) She admitted that petitioner informed her that he was participating in martial art activities as well as lifting weights and jogging. (pg. 41) She also testified that petitioner informed her he was capable of driving. (pg. 41) She testified that during her examination, the petitioner never mentioned his daily job search. (Pg. 51-53) Ms. Geist also testified that she did not feel there was any language barrier during her interview with the petitioner. (pg. 53) She also testified that during her initial meeting and interview with the petitioner he did not provide any job logs reflecting his job search. (pg. 53) She further testified that she was not provided petitioner's job logs until three years after her initial examination. (pg. 55) Ms. Geist testified that there would be a stable labor market for an embroidery job in Illinois. (pg. 61) Ms. Geist testified that a person off the street could become a medical assistant and that there was a stable labor market for medical assistants. (pg. 74) Ms. Geist testified that there was no way to determine from the job logs alone as to whether petitioner performed the job search as listed. (pg. 81) She also testified that the job search logs did not provide any information as to what job the petitioner was looking for. (pg. 84) She confirmed the job logs provided no information as to the petitioner providing a resume or filing out an application. (pg. 86) Ms. Geist testified that in her expertise and her practice a job search log would consist of, how the response was, happened, was there an interview. (pg. 89) Ms. Geist testified that she had no knowledge of petitioner's actual physical restrictions at the time of her testimony. (pg. 91) Ms. Geist testified that petitioner would be capable of working as a car salesman. (pg. 96) Ms. Geist testified that the petitioner is employable in a stable labor market. (pg. 100)

Trial Testimony of Ms. JoAnn Richter – Respondent's Vocational Expert

Ms. JoAnn Richter testified on the second date of hearing, September 10, 2014. She testified as a vocational expert for the respondent. Ms. Richter's qualifications were briefly described but detailed in her curriculum Vita. (Reps. Ex #1) Ms. Richter testified that she reviewed petitioner's job search logs and found numerous inconsistencies including, phone numbers that were disconnected as well as businesses that were no longer open. She testified to the medical records she reviewed and her understanding as to petitioner's physical abilities. Ms. Richter testified that all the knowledge she had with respect to the petitioner's age, education and employment background as well as his current abilities was derived from the reports of Ms. Geist. Her understanding of petitioner's medical condition was derived from the medical records provided to her by respondent's attorney. It was Ms. Richter's opinion that petitioner did not perform an adequate job search. This opinion was based on the fact that there was no information indicating that any follow up was ever performed as to any of the alleged job searches and very little if any information as to what positions petitioner was attempting to obtain. Ms. Richter was of the opinion that there was a stable labor market for the petitioner within his abilities. She felt petitioner would not likely benefit from vocational rehabilitation based on what she believed to be a lack of genuine effort on the petitioner's part to obtain employment up to the point of hearing. She also testified that based on her research petitioner was qualified and capable of working in a stable labor market.

ARGUMENT

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

This Arbitrator finds petitioner's current condition is causally related to the accident on July 17, 2008 to the extent that he is incapable of returning to work as an over the road trucker driver for the respondent or performing any type of heavy labor.

The accident sustained and the surgery petitoner underwent as a result of the accident are not in dispute. However, the results of the surgery and the physical abilities petitioner is allegedly capable of performing subsequent surgery are questionable and lack credible evidence to support. A review of Dr. Montella's treatment records after surgery on September 29, 2009 are void of any specific work restrictions. This Arbitrator is of the opinion that petitoner reached maximum medical improvement as of March 26, 2010.

After March 26, 2010, petitioner was examined by Dr. Montella on three occasions. On April 26, 2010 petitoner was taken off work for one month. On January 7, 2011 was taken off work for two months. On August 29, 2012, the records indicate petitoner reached maximum medical improvement, no work restrictions were provided.

Contrary to Dr. Montella's own treatment records, he testified that petitoner actually reached MMI as of January 7, 2011. (Pet. Ex #14 pg. 27) Further testimony indicates that Dr. Montella simply said petitioner was incapable of heavy labor. (Pet. Ex #14 pg. 28) This testimony does not support petitioner's allegation that he is incapable of performing any physical activity beyond light duty with the ability to change positions as needed.

This Arbitrator recognizes Dr. Montella provided a note dated September 16, 2013 opining petitioner was totally disabled from working in any capacity. (Resp. Ex #7) However, two factors completely contradict that opinion. The first being petitioner was actually working a full time, forty hour a week job when the note was provided and secondly petitioner himself at this hearing is not even alleging he is permanently and totally disabled. This not only calls into question the credibility of that note and the restrictions provided on the note, but it call into question the credibility of any of Dr. Montella's restrictions. Dr. Montella prescribed and testified to ordering an FCE pursuant to his examination on April 26, 2010. (Pet. Ex # 14 pg. 27) Then he testified later in the same deposition that he is not a fan of FCEs. (Pet. Ex #14 pg. 36) The legitimacy of Dr. Montella's restrictions is further questioned by the fact that he changed his opinion from his deposition testimony on June 24, 2011 that petitioner could not

perform heavy labor, to petitioner being unable to work in any capacity without even examining him.

This Arbitrator further questions the severity and limitations as a result of petitioner's injury based on circumstantial evidence provided at trial. In February of 2009, petitioner voiced concerns of his finger fracture and how it would respond if he had to get into a fight. (Pet. Ex. #12) At the time of this visit petitoner was making complaints of debilitating back pain. (Pet. Ex. #11) This Arbitrator questions why someone that could barely move because of his back pain was concerned with getting into a fight. This Arbitrator also points out that despite petitioner's allegations and the doctor restrictions, he told Ms. Geist he was still jogging, lifting weights and practicing martial arts. Petitioner denied that he performed these activities since the accident, but this Arbitrator questions that testimony. This Arbitrator also questions petitioner's testimony as to his ability to sit and drive. Petitoner stated he had pain while sitting and driving, but still was able to drive back and forth from Chicago to Miami on multiple occasions, a distance of over 1,300 miles. Petitioner also took a plane trip to the Ukraine, via a direct flight; it would take approximately ten hours.

The Arbitrator severely calls into question petitioner's vacation to Cancun Mexico. According to the medical records petitioner was examined by Dr. Montella in Elk Grove Village, IL on August 29, 2012. The records from this exam provide a history of complaints made by the petitioner. These complaints consisted of "increased pain with left side radiating leg pain, occasional numbness and tingling, flares ups more frequent, difficulty walking, standing or sitting, needs to adjust positions frequently, unable to to do any lifting...." (Pet Ex #11) Despite these complaints and being homeless, within three days of this exam, petitioner was somehow able to travel 1,300 miles to Miami and buy a round trip plane ticket and fly to Cancun, Mexico for a vacation, which was documented by the picture dated September 2, 2012 and testified to by the petitioner. (Resp. Ex # 8) The allegations made by the petitioner to Dr. Montella on August 29, 2012 as to his complaints of pain and physical abilities do not match petitioner's actions of being able to go from Chicago to Cancun in three days. It also calls into questions petitioner's allegation that he has been homeless since 2010.

The evidence in its totality supports the position that petitioner is unable to work as an over the road driver for the respondent or perform any type of heavy work for that matter, but does not support the alleged debilitating pain and restrictions petitioner alleges are necessary.

J. Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

This Arbitrator finds respondent is liable for a total of $330.00 in outstanding medical charges. This amount was stipulated to by the respondent at the time of hearing.

K. What Temporary Benefits are in dispute?

Temporary Total Disability

This Arbitrator finds the proper time period of Temporary Total Disability was paid by the respondent. Respondent paid benefits from July 18, 2008 through September 11, 2008 and again from December 6, 2008 through March 26, 2010. During this time period both parties stipulated that respondent paid $50,201.69.

However, due a stipulated change in petitioner's average weekly wage immediately prior to proceeding to trial, the amount owed by respondent was under paid. Based on the change in Average Weekly Wage, petitioner should have been paid $51,811.76 in Temporary Total Disability.

Thus respondent is liable for an additional amount of $1,610.07 in Temporary Total Disability, due to the stipulated change in average weekly wage, over the time period awarded.

This Arbitrator finds as of March 26, 2010 the petitoner had reached maximum medical improvement. On this date Dr. Steven Delheimer opined petitoner had reached MMI. (Resp. Ex #5) A review of the records indicated that two weeks prior to petitioner's exam with Dr. Delheimer he was seen by Dr. Montella. At that time petitioner's complaints remained the same. Dr. Montella prescribed physical therapy and chiropractic treatment, but there is no evidence that petitioner underwent this additional treatment. Furthermore, at this time, no work restrictions were provided. (Pet. Ex #11) The Arbitrator also points out that a month after the Section 12 exam petitoner was seen by Dr. Montella, on April 26, 2010. Petitioner's condition remained the same. An FCE was ordered to determine petitioner's work ability. (Pet Ex #11) This Arbitrator finds that the ordering of this test by Dr. Montella supports Dr. Delheimer's the finding that petitioner had reached a state of maximum medical improvement. Once again there was no evidence of additional treatment undertaken. The last evidence of any treatment rendered besides periodic examinations by Dr. Montella was the physical therapy and chiropractic care petitioner underwent in December of 2009.

Based on the finding that petitioner reached a state of maximum medical improvement on March 26, 2010, he would no longer be entitled to Temporary Total Disability Benefits beyond that date.

Temporary Partial Disability

This Arbitrator finds the petitioner was not paid the proper amount of Temporary Partial Disability from September 12, 2008 through December 5, 2008. While working light duty for the respondent petitioner earned $767.64. (Pet. Ex #16) If petitioner would have been working his full duty position he would have earned $12,256.17 during that same period of time. This creates a difference of $11,489.00. Under the Act petitioner would be entitled to two thirds of that amount or $7,659.33. According to the differential

payment information supplied by the respondent only, $2,143.99 was paid in differential benefits for this time period. (Resp. Ex #6) Thus petitioner is entitled to an additional $5,515.34 in temporary partial disability benefits.

Maintenance Benefits

This Arbitrator finds that petitoner is not entitled to maintenance benefits. The Arbitrator finds that petitioner did not sustain his burden of proof to be entitled to maintenance benefits. This Arbitrator finds that petitioner's job search and the logs representing that search were inadequate. It should be further noted that respondent was not provided evidence of the job search logs until August 27, 2013. (Resp. Ex #9 & #11) This alone would prevent respondent from being liable for benefits until that date in time.

With respect to petitioner's testimony regarding his job search, this Arbitrator finds numerous inconsistencies. Petitioner testified that he looked for work from March of 2010 through the time of Arbitration, September 9, 2014. The job logs indicate that from October of 2010 through November 2010 petitioner looked for work in Chicago and in December of 2010 looked for work in Florida. However, petitioner testified that during this period of time he was living in the Ukraine. The Arbitrator finds petitioner's testimony that he contacted the Chicago and Florida employers via phone or internet from the Ukraine lacking credibility. The job search logs also indicate that petitoner was looking for work in Florida from December of 2010 through September of 2012. According to petitioner's medical records he was examined by Dr. Montella in January 2011 in Elk Gove Village IL. Petitioner testified that he was not always living in the area he was looking for work. However, this Arbitrator finds that looking for a job in a state that you currently do not reside does not support evidence of an adequate job search. It is also noted that petitoner testified he was working with homeless shelters in the Chicago area from November 14, 2012 through May 2, 2013. (Pet. Exhibit #22) However, from mid-January 2013 through May 2013, petitioner was looking for work in Florida. Once again, this Arbitrator finds it severely questionable that someone would be living in Illinois but solely looking for work during that same period of time in the state of Florida. In addition this Arbitrator cannot ignore the fact that at the time petitoner was interviewed by petitioner's own vocational expert, Ms. Geist, he provided an extremely detailed history of his daily activities from the moment he woke up to the moment he went to bed and despite the fact he was allegedly looking for a job at least twice a day he never mentioned once of performing this activity. By the time petitoner was interviewed by Ms. Geist, for the purpose of a vocational assessment, he had allegedly looked for over 100 jobs. However, throughout the extensive interview performed, there is no mention of his job search. This omission severely questions the credibility of petitioner's testimony that he actually contacted the employers listed in his job logs as alleged.

Looking at the job search logs, this Arbitrator finds that they lack the sufficient proof to be considered adequate. The job search logs consist of 47 pages. The first three pages of the job logs provide partial information as to the employer contacted, the person the petitioner spoke with and the position applied for. Beginning on page one, there are only

thirteen employers listed but over 75 phone numbers. Within those first five pages petitioner listed jobs he was physically incapable of performing and jobs he was unqualified for. The first page of petitoner's job log search is filled with CDL truck driving companies. Petitoner testified that he was looking for jobs with these employers other than driving a truck, but that is contrary to his own logs. Some of the entries specifically indicate a dispatcher position or other positions he was inquiring about. Why would a person list the position he was looking for sometimes but not all the time. He also applied for positions as a mover or taxi driver. Positions he testified he was restricted from performing or incapable of performing.

In the case of *Wheeler v. Baldwin Manufacturer*, the Commission found petitoner's job search to be inadequate because he applied for positions he was unqualified for or places that were not hiring. *Wheeler v Baldwin Manufacturer*, 11 W.C. 34788, 14 I.W.C.C. 0120 A similar finding was provided in the case of in the case of *Burnett v Weaver Enterprises,* the Commission found the claimant's job search to be inadequate when the records listed only names of companies and occasionally the address. There was no specific information concerning the date of the alleged contact, name of person contacted, position applied for or the result of the alleged contact. *Burnett v Weaver*, 03 W.C. 48504, 09 I.W.C.C. 1255

Furthermore, starting on page five of the job log sheets, there are only names and phone numbers of Hotel, pizza restaurants, libraries and addresses, which petitioner testified were gas stations. This Arbitrator finds that 42 of the 47 pages provide no information as to the position of employment the petitoner was looking for or the result of the contact. Furthermore, this Arbitrator points out that petitioner himself testified the job search logs were copied and pasted from the internet. A review of the job logs indicate that of the 47 pages provided, there is not one indication a resume was provided or an application was filled out. In the case of *Sparkman v Aventine Renewable Energy*, the Commission found "while the claimant testified to contacting several places about a job and checking papers, he also testified he made no in-person job applications. The claimant failed to provide any evidence of the results of his search, what companies he contacted, or who he contacted at these companies. The claimant also made no request for vocational assistance. Thus the Commission finds the evidence presented of a job search to be inadequate, and lacking in credibility". *Sparkman v Aventine Renewable Energy*. 08 W.C. 21887, 11 I.W.C.C. 0492
Despite the fact this Arbitrator did not find the testimony of respondent's expert vocational counselor compelling, it is unrefuted that she was the only person that contacted some the employers on the job search logs, besides the petitioner, and found numbers were disconnected and many of the employers were no longer in business. Irrespective of the lack of credibility of petitioner's testimony of his job search, this Arbitrator cannot find a list of employers and phone numbers evidence of an adequate job search to sustain his burden that there is no stable labor market for him to be employed in. In the case of *Witherspoon v White County Coal Company*, the Commission found petitoner job search to be inadequate and stated, "The law is clear. It does not emphasize the number of contacts but recognizes the type and quality of

contacts in job searches." *Witherspoon v White County Coal Company,* 06 W.C. 26188, 06 W.C. 26189, 11 I.W.C.C. 0114.

This Arbitrator points out that petitioner had a minimum of four separate jobs prior to his accident. This testimony shows petitioner knew what was necessary to try and find a position of employment which included in person conversations and completion of applications. Simply copying and pasting employers and their phone numbers from the internet onto a piece of paper and saying you called each one does not sustain the necessary burden of proof required by the petitioner.

Without an adequate job search or participation in vocational rehabilitation, this Arbitrator finds petitoner is not entitled to maintenance benefits under the Act.

L. What is the Nature and Extent?

This Arbitrator finds that petitioner is entitled to permanent partial disability pursuant to Section 8(d)(2) of the Act.

Pursuant to Section 8(d)(2), this Arbitrator notes petitoner underwent surgery to his lumbar spine and as a result this Arbitrator finds the evidence supports the fact that petitoner is precluded from returning to his position as an over the road driver or any heavy position. In light on this evidence, this Arbitrator finds petitoner sustained permanent partial disability equal to 40% loss of use of a person as a whole.

This Arbitrator also awards petitioner 5% loss of use of his right middle finger under Section 8(e) of the Act as a result of a sprained right middle PIP joint.

M. Should Penalties and Fees be imposed on the Respondent?

This Arbitrator finds that respondent's denial of any benefits in this case was not unreasonable or vexatious. Thus, no penalties or fees are award based on the amounts owed.

O. Other

Petitoner's Entitlement to Vocational Rehabilitation

This Arbitrator finds petitioner is not entitled to vocational rehabilitation based on the fact that no evidence has been brought that proves it would increase petitioner's earning capacity. "A claimant has been deemed entitled to rehabilitation where he sustained an injury which caused a reduction in earning power and there is evidence rehabilitation will increase his earning capacity." *National Tea v Industrial Commission*, 73 Ill Dec. 575, 454 N.E.2d 672,

Ms. Geist, petitoner's own expert, provided no testimony that vocational rehabilitation would increase his earning capacity. Thus petitioner has not sustained his burden of proof that he is entitled to vocational rehabilitation.

Petitioner's Entitlement to Benefits Pursuant to Section 8(d)(1)

This Arbitrator is of the opinion that petitoner has not sustained his burden of proof as to entitlement to benefits under Section 8(d)(1). To qualify for a wage differential award, the petitioner must show that the disability has caused (a) a partial incapacity that prevents him or her from pursuing his or her "usual and customary line of employment" and (b) impairment of earnings. *Albrecht v. Industrial Commission*, 271 Ill.App.3d 756, 648 N.E.2d 923, 925, 208 Ill.Dec. 1 (1St Dist. 1995).

This Arbitrator finds petitioner is prevented from returning to his previous position of employment. However, this Arbitrator does not find that petitioner has sustained his burden of proof that he has suffered a reduction in earning capacity.

Although petitioner was able to obtain minimum wage employment at Larissa's Embroidery, this Arbitrator questions the legitimacy of this position of employment. Petitioner was allegedly paid by check with no taxes deducted. The address on the check indicates petitoner was living in Morton Grove, IL despite the fact petitioner stated he was homeless since December of 2010. This Arbitrator also opines that the average earnings from this position do not truly reflect his full earning capacity. This Arbitrator is of the opinion petitioner obtained this minimum wage position in effort to increase his possible worker's compensation award and does not reflect his true earning potential. This finding is comparable to the case of *Frederickson v. Labotz Exteriors*. In that case the court found there was no evidence presented by the claimant of a valid job search and nothing presented to evidence that $7 per hour was the most the claimant would be able to earn within his restrictions, thus there was insufficient proof of wage loss. *Frederickson v. Labotz Exteriors,* 00 W.C. 09651, 09 I.W.C.C. 0610

This Arbitrator finds respondent's expert's opinion regarding earning capacity lacked credibility and petitioner's expert, Ms. Geist, lacked any true understanding of what petitoner's restrictions truly were, and thus was unqualified to provide a credible opinion on petitioner's earning capacity at the time of hearing. Furthermore, Ms. Geist testified to what type of position petitoner was capable of working in a stable labor market but never specifically stated what petitioner's earning potential was even based on the restrictions she thought he required. This Arbitrator finds that neither petitioner nor respondent's expert provided a credible opinion as to petitioner's earning potential within his reduced physical capacity, and without an adequate job search, it would be pure speculation to find petitioner sustained a reduced earning capacity, thus qualifying for benefits pursuant to Section 8(d)(1) .

It should also be pointed out that petitioner did not provide evidence at to what his earning capacity would have been presently if he was still working in his prior capacity. Petitoner wage records from prior to accident indicate that the amount of hours he

worked and the miles he drove varied greatly. No evidence was provided as to the amount of hours he would be required to work or the miles he would be required to drive if still working for respondent. Evidence was provided indicating the hourly rate for petitioner's previous position increased and the amount per mile the petitioner might have been paid increased. (Pet. Ex #19) However, no evidence was provided as to the amount of hours petitioner would have been required to work or the amount of miles petitioner would have been required to drive. Petitioner testified that an over the road assignment consisted of 600 miles. However, the paystubs provided by petitioner detailing the work he performed prior to the accident contradict this testimony. Those pay stubs indicate the hours worked fluctuated from week to week as well as the amount of miles driven from week to week. To automatically assume a certain amount of hours would be driven or worked would be pure speculation, which would not support petitioner burden of proof on this issue.

Based on the lack of evidentiary support to find petitioner is entitled to vocational rehabilitation or benefits under Section 8(d)(1), this Arbitrator finds petitioner is entitled to benefits pursuant to section 8(d)(2) and 8(e).

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

Ofelia Martinez,
Petitioner,
vs.
Park Hyatt,
Respondent,

NO: 12WC 14121

15IWCC0624

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,744.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 13 2015
MJB/bm
o-08/11/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MARTINEZ, OFELIA
Employee/Petitioner

Case# 12WC014121

15IWCC0624

PARK HYATT
Employer/Respondent

On 1/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0307 ELFENBAUM EVERS & AMARILIO
IAN ELFENBAUM
940 W ADAMS ST SUITE 300
CHICAGO, IL 60607

2461 NYHAN BAMBRICK KINZIE & LOWRY
CHRISTOPHER GIBBONS
20 N CLARK ST SUITE 1000
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ofelia Martinez
Employee/Petitioner

v.

Park Hyatt
Employer/Respondent

Case # **12** WC **14121**

Consolidated cases: ____

15IWCC0624

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **December 5, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$30,368.00**; the average weekly wage was **$584.00**.

On the date of accident, Petitioner was **55** years of age, *single* with **1** dependent children.

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

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

Respondent shall be given a credit of **$841.14** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$841.14**.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d) (2) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $350.40/week for 25 weeks, because the injuries sustained caused the 5% loss of the use of the person as a whole, as provided in Section 8(d)(2) of the Act.

The Petitioner is entitled to TTD for the period of April 2, 2012 through May 21, 2012. The Respondent shall pay the Petitioner temporary total disability benefits of $ 389.33 /week for 7 weeks, from April 2, 2012 through May 21, 2012 , which is the period of temporary total disability which compensation is payable. Respondent shall receive a credit of $841.14, for TTD payments which have been previously made.

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

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

Deborah L. Simpson
Signature of Arbitrator

Dec. 30, 2014
Date

JAN 5 - 2015

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ofelia Martinez,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 12 WC 14121**
	)	
Park Hyatt,	)	
	)	
Respondent.	)	15IWCC0624
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on March 23, 2012, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. On that date the Petitioner sustained an accidental injury or was last exposed to an occupational disease that arose out of and in the course of the employment and the Petitioner gave the Respondent notice of the accident within the time limits stated in the Act. The parties further agree that the Petitioner's current condition of ill-being is causally connected to the accidental injuries. The Petitioner's earnings during the year preceding the injury were $30,368.00 and her average weekly wage calculated pursuant to Section 10 of the Act was $584.00; all medical bills have been paid pursuant to the fee schedule.

At issue in this hearing is as follows: (1) Is the Petitioner entitled to TTD from April 2, 2012 through May 21, 2012 or April 2, 2012 through April 17, 2012; and (2) what is the nature and extent of the injury.

The Petitioner testified with the assistance of Claudia Perez, a certified interpreter, who was duly qualified and accepted by both parties.

STATEMENT OF FACTS

The Petitioner was hired by the Respondent in 2002. She spent the first two years as a turn down attendant. She was later assigned to work in the public areas and had been there for ten years as of March 23, 2012, the date of the accident. Her job duties in the public areas include: cleaning and maintaining the bathrooms by putting up towels and cleaning the toilets on the seventh floor, cleaning the lobby glass, floors and public area including where they put the beverages, as well as the employee area and the big banquet hall. The Petitioner testified she performed excellent service and met the high standards of the Park Hyatt all of these years.

On March 23, 2012, when she was walking through the big banquet hall, while walking past a table, she slipped on a piece of food on the bare floor. As the Petitioner slipped, there was

nothing to hang onto because the tables are bare when there are no events, her body twisted and she fell to the floor, landing on her tailbone. She felt pain but not strong. She reported her injury to her supervisor but continued working that day. By the end of her shift, the low back pain had increased. Petitioner did not seek medical treatment for the injury until April 2, 2012.

Petitioner asked her attorney for a list of doctors and picked the one who was closest to her home, Dr. Michael Foreman. Doctor Foreman had an interpreter for her; he did an examination of Petitioner and sent her for X-rays, took her off of work and sent her for physical therapy. The Petitioner testified she attended physical therapy which consisted of various stretching exercises, heat therapy and massage.

A review of the Petitioner's medical records indicates that on April 2, 2012 she saw Dr. Foreman who wrote in his chart note, "Ms. Martinez was on duty as a hotel porter when she slipped and fell on a slippery surface striking her low back on the ground." The Petitioner reported to Dr. Foreman that she had low back pain that was made worse by standing from a seated position or weight bearing activities as a result of her March 23, 2012 accident. Dr. Foreman noted limited range of motion and increased tenderness in L1 – L5 and sacral region. Dr. Foreman recommended physical therapy and took the Petitioner off work until her next visit on April 26, 2012. (PX 1, p. 1, 4; PX. 3, p. 3).

On April 16, 2012, the Petitioner saw Respondent's examiner, Dr. Singh, pursuant to Section 12, who recommended: (1) an MRI of the low back; (2) a ten pound lifting restriction; (3) stated she was not at MMI; (4) Found her injury is related to her work event; and (5) Petitioner needed at least four more weeks of physical therapy. (RX. 2). Subsequently the Petitioner received a phone call from her supervisor, Jim Parsons, offering her light duty. She told him she was going to follow Dr. Foreman's advice and stay off work due to her pain. Her TTD was terminated. (PX. 1).

On April 26, 2012 the Petitioner again saw Dr. Foreman who noted therapy consisted of interferential electric current, hot packs and mechanical traction which helped decrease her pain and spasms, but her symptoms persisted. Dr. Foreman ordered another session of physical therapy and kept the Petitioner off work until her next visit. Dr. Foreman noted the case manager had asked for a MRI. (PX 1, p. 5; PX 3, p. 3).

On May 1, 2012, the Petitioner had the MRI of her lumbar spine which showed a disk bulge/protrusion at L4-L5 level. (PX. 2). She continued physical therapy in May (PX. 4, pp. 8-32) and her pain was getting better with the physical therapy. According to the Petitioner it hurt to walk, she described the pain as a sharp, pinching pulling pain back by her tailbone.

On May 17, 2012, the Petitioner saw Dr. Foreman who sent the Petitioner back to work full time at regular duty as of May 21, 2012. (PX. 1, p. 6; PX. 2).

The Petitioner testified she had to work very slowly and every task took her twice as long to complete and every day, after work, she would have more pain in her back and through her legs. When she tried to go faster, she got a sharp, pulling, pinching pain in her tailbone.

On June 7, 2012, the Petitioner again presented to Dr. Foreman and reported that physical therapy had been slowly improving her ability to function at work and her tolerance to home exercises but she still needed pain medication. She continued to attend therapy sessions and reported to Dr. Foreman physical therapy and massage therapy helped her. Dr. Foreman provided her with a portable combination EMS/TENS unit. (PX. 3, p 5). The Petitioner testified it helped her a lot and she still uses the EMS/TENS unit today. It enabled her to continue to work at her regular job.

On July 6, 2012, the Petitioner saw Dr. Foreman and reported to him that she was having a hard time tolerating her work duties as her light lifting work restrictions were not being honored. Dr. Foreman gave her a work restriction note providing clarification of the Petitioner's physical capabilities. He also started her on a work conditioning program at AMCI (PX. 1, p. 7; PX 5, pp. 52-54) to be followed by a functional capacity evaluation. (PX 3, p 5; PX 5, pp. 29-39).

On July 20, 2012 an initial work conditioning evaluation took place at Associated Medical Centers of Illinois, ("AMCI"). The Petitioner reported "pain in her lower back with associated radiculopathy into both legs after walking for more than 30 minutes." (PX 5, p.51) The AMCI records note further that Petitioner has increased pain when performing daily activities such as walking and functional activities including bending and lifting. "The patients functional deficits in her daily activities and work duties have prevented her from performing work related activities as a lobby porter in a pain free and safe fashion." (PX 5, p. 52) Dr. Sirotininskiy ordered work conditioning 3 times per week for 3 weeks followed by an FCE. (PX, p. 53)

The Petitioner testified she attended seven sessions where she participated in exercises which helped her to perform her work activities. Her discharge evaluation stated her main complaints continue to be pain, soreness and fatigue after lifting objects over thirty pounds and strenuous activity yet she wants to return to work with no restrictions. (PX. 5, p. 41).

On August 9, 2012, the Petitioner presented at AMCI for a Functional Capacity Evaluation (FCE). A job description in the FCE states: "This position was described as lifting 20 lbs frequently and up to 40 lbs occasionally with overhead lifting up to 10 pounds. Standing for the entire shift was required as well as squatting and bending frequently." (PX 5, p. 28). The report went on to conclude, "Her job is medium PDC. Her recommended PDC was medium with limitations: Qualified: 45# occasional, 23# frequent and 9# constant. Safe/recommended of 36# occasional, 18# frequent and 7# constant. (PX. 5, p. 38). Her FCE was determined as being valid. (PX. 5, p. 37).

On August 16, 2012 following her functional capacity evaluation and work conditioning program, the Petitioner saw Dr. Foreman for the last time. She was released from medical care with permanent restrictions of occasional lifting of up to 35 pounds, frequent lifting of up to twenty pounds and constant lifting up to ten pounds starting the next day. (PX. 1, p. 8; PX 3, p.6). The Petitioner testified she tried to work within these restrictions which were essentially her regular job.

The Petitioner testified Respondent's second Section 12 examiner, Dr. Gleason, saw her for about eight minutes for an exam on October 30, 2012, (RX. 1) and she has been working full duty since she went back to work May 21, 2012. Her personal doctor has given her Naprosyn to deal with her pain at work and she said she has also been using the TENS unit about three times a week.

Respondent's witness, Jim Parsons, testified that he does remember that the Petitioner reported her accident; he was there as was the Petitioner's supervisor. Petitioner said she slipped and caught herself, but did not fall to the ground. Petitioner does not come to him to complain about any work problems. He is not generally in the public areas but he does see Petitioner in the hallway. He has not seen her doing anything out of the ordinary when doing her job, and Petitioner does not seem to be in pain when he sees her working. Mr. Parsons did acknowledge that pain is not observable. Mr. Parsons does not speak Spanish so communication with the Petitioner is limited as her primary language is Spanish. Mr. Parsons could not recall Petitioner's medical restrictions at the time he made the offer of light duty work to her. He admitted that he was aware the Petitioner had a "no work" restriction per her treating physician at the time the offer was conveyed.

Dr. Gleason testified, by evidence deposition, that he performed an American Medical Association (AMA) impairment evaluation of the Petitioner. (RX. 1) He was of the opinion the Petitioner has a 1% whole person AMA rating per the Sixth Edition of the AMA Guides to Evaluation of Permanent Impairment (RX. 1, p. 33) due to this injury. On cross examination Dr. Gleason acknowledged he did not review the MRI (RX. 1, p. 46), treating medical records (RX. 1, p. 41), administer the PDQ (RX. 1, p. 43) or supply a professional interpreter while performing his AMA evaluation (Rx. 1, p. 53).

The Petitioner testified that before her work place injury she enjoyed walking fast, being able to do her job quickly, lifting heavy things and sleeping through the night. She has curtailed these activities now. Her tailbone hurts at work. She feels a pulling even when she lies down. When she works she can sit only when she folds towels. She has to put a rolled up towel behind her lower back to relieve the pain which she described as a ball, pinching, sharp pain that goes to her legs and her backside and increases the more she works. The Petitioner still relies on the TENS unit as needed to relieve her pain.

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

In determining the level of permanent partial disability, for injuries that occur on or after September 1, 2011, the Commission shall base its determination on the following factors: (i) the reported level of impairment pursuant to subsection (a); (ii) the occupation of the injured employee; (iii) the age of the employee at the time of the injury; (iv) the employee's future earning capacity; (v) evidence of disability corroborated by the treating medical records. No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order. (820 ILCS 305/8.1b)

What amount is due for temporary total disability?

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits.

Petitioner testified she was "off work" per the instructions of her treating doctor, Dr. Foreman at the time of her Section 12 examination. She stated that at the time, she could not walk very well. Dr. Singh felt her condition was serious enough to warrant an MRI, and that Petitioner was not at MMI at the time, but she could work in a very restricted capacity. The Respondent offered light duty to the Petitioner based upon the recommendation of Dr. Singh. Mr. Parsons acknowledged that at the time the offer was made, he was aware of the no work restriction imposed by Dr. Foreman. Mr. Parsons testified that they have a light duty program but, was not able to describe what the light duty work he was offering included.

The Petitioner turned down the offer of light duty work, explaining that "I cannot work because I felt a lot of pain, I could not walk well and it's my body, not the doctors."

The Arbitrator finds the Petitioner's refusal of the light duty work, without even attempting it, was not unreasonable under the circumstances. Petitioner's treating physician had taken the Petitioner off of work because of her injury and the condition it left her in. She was obviously in pain at the time, and in need of further diagnostic studies according to the Section 12 examiner. Dr. Singh had recommended an additional four weeks of physical therapy depending upon the MRI results. (RX. 2). Based on the totality of the medical evidence, the ongoing disability and treatment of the Petitioner and her personal physician's "no work" order from April 2, 2012 - May 21, 2012 (PX. 1, p. 5) the Arbitrator awards TTD for the seven week period that the Petitioner was off of work due to her injury.

What is the nature and extent of the injury?

The Arbitrator adopts by reference all prior findings and conclusions into this Section without restating them herein. This claim arose after September 1, 2011, therefore the 5 factors for determining Permanent Partial Disability shall be applied here. The Arbitrator notes the five factors to determine Permanent Partial Disability are: 1) AMA Impairment Rating; 2) Occupation of the injured employee; 3) Age of the employee at the time of the injury; 4) Employee's future earning capacity; and 5) Evidence of disability corroborated by the treating medical records. No one factor shall be controlling but a written explanation is required if an award is greater than the AMA Impairment Rating. 820 ILCS 305/8.1b(b).

It is the claimant's burden to prove all aspects of his claim for benefits. This includes entitlement to Permanent Partial Disability.

1. ***AMA Impairment Rating***: The AMA rating of Dr. Gleason is not accorded much weight by the Arbitrator in that Dr. Gleason did not follow the AMA's guide of recommended procedures and protocol in administering his exam and issuing his report. The guidelines state:

> Functional assessment should be one aspect of impairment rating, but not the only aspect. Diagnosis, history, and physical examination; appropriate confirmatory tests; and functional outcome scores must all be incorporated. The rating physician using the "guides" should weigh all available information, emphasizing the importance of some and deemphasizing other information, so long as it is consistent and concordant with the pathology at issue." (American Medical Associations, Guides to the Evaluation of Permanent Impairment, Sixth Edition, April, 2009, p. 10, § 1.7b). As tests are the most objective source of data available, the results that would lead to a patient being placed in one class, as opposed to another must be described as specifically as possible in the chapter and in the guide itself. (American Medical Associations, Guides to the Evaluation of Permanent Impairment, Sixth Edition, April, 2009, p. 15, § 1.8g).

Dr. Gleason directly stated in his opinion he did not need the MRI or treatment records to perform an AMA rating. He chose not to administer the Pain Disability Questionnaire although it is the preferred pain inventory for AMA spine ratings (American Medical Associations, Guides to the Evaluation of Permanent Impairment, Sixth Edition, April, 2009, p. 11 and p. 600). Additionally, he did not use a professional interpreter as suggested in the AMA Guide:

> Cultural differences between the examiner and the patient can greatly increase the risk of the examiner misunderstanding the patient's responses. The examiner should ensure the involvement of a qualified interpreter for the impairment examination. (American Medical Associations, Guides to the Evaluation of Permanent Impairment, Sixth Edition, April, 2009, p. 27, §2.5g).

Despite the above listed deficiencies he opined that the Petitioner sustained a permanent impairment of 1% per the AMA guidelines.

2. ***Occupation of the injured employee***: Petitioner was employed by Respondent as a maintenance engineer, responsible for cleaning and maintaining the bathrooms by putting up towels and cleaning the toilets on the seventh floor, cleaning the lobby glass, floors and public area including where they put the beverages, as well as the employee area and the big banquet hall. Petitioner testified that she continues to work for Respondent within the restrictions that her physician placed on her when she was released from treatment. The Arbitrator gives some weight to this factor.

3. ***Age of the employee at the time of the injury***: Petitioner was 55 at the time of her accident. There is no evidence that Petitioner's age impacted her injury or created any permanent disability. The Arbitrator gives some weight to this factor.

4. ***Employee's future earning capacity***: Petitioner testified that she continues to work for the Respondent and that the lifting restrictions placed upon her have been honored by her employer. Petitioner did not testify to any diminution of her earnings since this accident. There is no evidence of disability due to this factor. The Arbitrator gives little weight to this factor.

5. ***Evidence of disability corroborated by the treating medical records***: The Petitioner sustained an injury to her lower back.

The Petitioner's low back injury led to a four month course of treatment resulting in a medium duty FCE and restrictions of lifting thirty-five pounds occasionally, twenty pounds frequently and ten pounds constantly per Dr. Foreman. "Her restrictions may be advanced if the patient feels able yet these may be permanent. She was discharged from therapy and further care." (PX. 3, p. 6).

The medical records corroborated the testimony to low back pain in her tailbone, pain upon sitting and pain down her legs. The MRI of her lumbar spine showed a disk bulge/protrusion at L4-L5 level. (PX. 2).

The Petitioner testified that she cannot walk as fast as she used to, cannot work as fast as she used to, and cannot lift or pull heavier items like she used to be able to do. Petitioner testified that she cannot sit for long periods of time, must put a towel behind her by her back and she is in constant pain in her lower back. She still relies on a TENS unit for pain control and takes prescription pain medication. She does not have any future doctor appointments or plans to make any appointments for additional treatment.

Given the nature of the injury the Petitioner suffered to her lower back following the March 23, 2012, incident, she is entitled to have and receive from the Respondent compensation for 5% loss of use of the person as a whole, or 25 weeks at a weekly PPD rate of $350.40 / per week.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d) (2) of the Act. Respondent shall pay Petitioner permanent partial disability benefits of $350.40/week for 25 weeks, because the injuries sustained caused the 5% loss of the use of the person as a whole, as provided in Section 8(d)(2) of the Act.

The Petitioner is entitled to TTD for the period of April 2, 2012 through May 21, 2012. The Respondent shall pay the Petitioner temporary total disability benefits of $ 389.33 /week for 7 weeks, from April 2, 2012 through May 21, 2012 , which is the period of temporary total disability which compensation is payable. Respondent shall receive a credit of $841.14, for TTD payments which have been previously made.

Deborah L. Simpson — Dec. 30, 2014

Signature of Arbitrator — Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isaac Atilley,

Petitioner,

vs.

NO: 09WC 41911
09WC 41912
10WC 26667

The Habitat Company,

Respondent,

15IWCC0625

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 20, 2014, is hereby affirmed and adopted.

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

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

15IWCC0625

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

DATED: AUG 13 2015
MJB/bm
o-08/11/15
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ATILLEY, ISAAC
Employee/Petitioner

Case# **09WC041911**

09WC041912

10WC026667

THE HABITAT COMPANY
Employer/Respondent

15IWCC0625

On 8/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5271 LEADERS LAW CENTER LTD
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STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Isaac Atilley
Employee/Petitioner

v.

The Habitat Company
Employer/Respondent

Case # **09** WC **41911**

Consolidated cases: **09 WC 41912**
10 WC 26667

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **July 31, 2013, February 28, 2014 and June 27, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Isaac Atilley,	)	
	)	
Petitioner,	)	
	)	
vs.	)	**No. 09 WC 41911**
	)	**09 WC 41912**
The Habitat Company,	)	**10 WC 26667**
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on August 8, 2008, March 5, 2009 and May 14, 2009, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They further agree that in the year preceding the injuries, the Petitioner earned $39,109.72, and that his average weekly wage was $752.11.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries or was he last exposed to an occupational disease that arose out of and in the course of employment; (2) Did the Petitioner give the Respondent notice of the accidents within the time limits stated in the Act; (3)Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (4) Is the Respondent liable for the unpaid medical bills for treatment at Northwestern Memorial Hospital, Northwestern Memorial Faculty Foundation, RIC and Flexion Rehab; (5) Is Petitioner entitled to TTD from May 14, 2009 through June 9, 2009, June 19, 2009 through July 6, 2009, July 13, 2009 through September 10, 2009, and January 15, 2010 through November 16, 2010; (6) What is the nature and extent of the injury; and (7) Is Petitioner entitled to penalties and attorney's fees under §§ 16 and 19 of the Act.

STATEMENT OF FACTS

The petitioner, Mr. Isaac Atilley, was employed by the respondent, The Habitat Company, a residential property management company, for approximately ten years as a janitor or maintenance man. During that time, the petitioner, a union member, performed maintenance work at the York Terrace Apartments, a property managed by the respondent. The petitioner alleges he sustained injuries to his low back while working in this capacity on August 8, 2008, March 5, 2009, and May 14, 2009.

FINDINGS

On **March 5, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

In the year preceding the injury, Petitioner earned $**39,109.72**; the average weekly wage was $**752.11**.

On the date of accident, Petitioner was **57** years of age, ***married*** with **2** dependent children.

ORDER

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

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

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

Deborah L. Simpson
Signature of Arbitrator

Aug 19, 2014
Date

AUG 20 2014

On October 7, 2009, the petitioner filed two Applications for Adjustment of Claim. The first Application for Adjustment of Claim, corresponding with case number 09 WC 41911, alleges an injury sustained on March 5, 2009 while mopping a floor at work. The second Application for Adjustment of Claim, corresponding with case number 09 WC 41912, alleges an injury sustained on May 14, 2009 while pulling a toilet at work. On July 9, 2010, the petitioner filed a third application. The third Application for Adjustment of Claim, corresponding with case number 10 WC 26667, alleges an injury sustained on August 8, 2008 when the petitioner bent down to rod a sink at work.

The petitioner testified that on August 8, 2008, while at work, he was rodding a sink. After that day he felt severe pain. When he went home he tried some ointment like Ben Gay just to ease himself. The following morning when he arrived at work the pain was more. He reported the injury to his supervisor Rex Oliver, and was given permission to see his doctor and went to see his primary care doctor, Evan Lu, M.D. Dr. Lu gave him pain medication which he took every day before work and it allowed him to perform his duties "without pain until something triggered it."

The petitioner testified that on March 5, 2009, he was at work. After cleaning up in the office he went into the lobby to clean. While mopping, he felt a severe pain in his back, his back was locked and he could not move. Petitioner asked the security guard to call his supervisor Rex Oliver and after the security guard relayed his instructions petitioner went to the emergency room. He stated he went to Northwestern Memorial hospital emergency room. He was instructed to see his primary care doctor so he went to see Dr. Lu. Petitioner testified that Dr. Lu gave him Norco for the pain and told him to have an MRI.

The petitioner then testified that on May 14, 2009, he was given a work order to pull a toilet. It was in apartment 1808. He testified that when he was pulling the toilet he felt some severe back pain. He stated that he was unable to finish the job, that he called and told them he had back pain and they asked him to go to the hospital. He testified that he went from the emergency room to Dr. Lu. Dr. Lu told him to go to Dr. Haak for an MRI. Petitioner testified that Dr. Haak sent him for physical therapy.

Medical Treatment

On August 11, 2008, the petitioner presented to Dr. Evan Lu, his primary care physician, with complaints of low back and left leg pain. (RX 9, p.85). The petitioner denied any history of trauma associated with the symptoms. (RX 9, p.90). The petitioner was diagnosed with sciatica, was prescribed ibuprofen and Norco, and was advised to return to treatment in three months. The petitioner testified that he continued to take Norco for low back pain through November 2008. (TX 7/31/13 p. 49). On November 10, 2008, he returned to Dr. Lu and was again provided with a prescription for Norco for sciatica and low back pain. (RX 9). The medical records corresponding with the November 10, 2008 office visit do not contain any reference to a work related injury or history of trauma.

The petitioner continued to take Norco for low back pain and sciatica through February 2009. The petitioner testified that he returned to Dr. Lu on February 28, 2009 with complaints of low back and bilateral leg pain. (TX 7/31/13 p.50; RX 9). The petitioner did not report a history

of work injury or trauma associated with the symptoms. (RX 9). Given the duration of his symptoms, Dr. Lu referred the petitioner for a lumbar MRI scan and an orthopedic consultation at the Northwestern Memorial Faculty Foundation (RX 9, p.112).

The recommended lumbar MRI scan was performed on March 6, 2009. (RX9) The March 6, 2009 MRI scan revealed multilevel degenerative changes with severe left and moderate right foraminal stenosis at L5-S1 as well as a mild loss of vertebral body height between L3 and L5. (RX 9). After the MRI scan was completed, the petitioner returned to Dr. Lu on April 15, 2009. (RX 9, p.135). The petitioner was advised to follow up with orthopedics as scheduled and was provided with a refill of Norco. (RX 9, p.135.)

As recommended, the petitioner then presented to Dr. Michael Haak of the Northwestern Memorial Faculty Foundation on April 21, 2009. (PX 14). The petitioner testified that when he presented to Dr. Haak on April 21, 2009, he completed a "New Patient Profile" questionnaire. (TX 7/31/13 p.51). The petitioner testified that he completed this form truthfully. (TX 7/31/13 p.51). The petitioner testified that he advised Dr. Haak that his low back pain began in April of 2008. (TX 7/31/13 p.52). The "New Patient Profile" questionnaire, completed by the petitioner, indicates that his pain began one year earlier, that he began taking medication for pain in March 2009, and that Dr. Lu had since referred him to Dr. Haak for an evaluation. (PX 14, p.11). The petitioner did not report that the condition was work related. (PX 14, p.11).

The April 21, 2009 office visit note of Dr. Haak indicates that the petitioner's symptoms of back and thigh pain had begun approximately one year earlier and had become more severe within the two months before the evaluation. (PX 14, p.9-10). Dr. Haak's report does not contain a history of a work injury connected with the petitioner's symptoms. Following an examination and review of the March 6, 2009 MRI scan, Dr. Haak diagnosed lumbar degenerative disc disease, lumbar radiculopathy, and lumbago. (PX 14, p.9-10). Dr. Haak opined that the petitioner was "symptomatic because of his underlying degenerative disc disease." (PX 14, p.10). Treatment options were discussed and the petitioner opted for an "aggressive approach." (PX 14, p.10). Dr. Haak referred the petitioner for physical therapy and to the Center for Spine, Sports and Occupational Rehabilitation of the RIC for epidural steroid injections. (PX 14, p.10). The petitioner was advised to return to Dr. Haak in eight weeks for a re-evaluation. (PX 14, p.10).

The petitioner testified that Dr. Haak referred him to Dr. Ihm at RIC. (TX 7/31/13 p.53). Before he could get an appointment with Dr. Ihm, he presented to the emergency room at Northwestern Memorial Hospital on May 14, 2009. (TX 7/31/13 p.53). The petitioner testified that upon presentation to the emergency room on the morning of May 14, 2009, he told the staff exactly what had happened causing him to seek treatment. (TX 7/31/13, p.53-54).

The May 14, 2009 records from Northwestern Memorial Hospital's emergency room indicate that the petitioner presented at 8:47am with complaints of lower back pain with radiation into the left leg. The petitioner reported that the pain had begun approximately 3 weeks before and had become severe the night before [May 13, 2009]. (PX 17). The petitioner specifically denied any trauma associated with the symptoms. (PX 17). The petitioner reported that the pain had become so great the night before that he had been unable to work on May 14, 2009 due to the level of pain. (PX 17).

Prior treatment was noted to have included a lumbar MRI scan and the petitioner reported that he had been trying to make an appointment with a specialist but had been unable to get in. (PX 17). The petitioner was diagnosed with low back pain, was given pain medication, and was advised to follow up with his primary care physician and orthopedic physician. (PX 17).

On May 19, 2009 the petitioner presented to Dr. Joseph Ihm. (PX 15). The medical report indicates that when initially asked, the petitioner first tried to tell Dr. Ihm that his low back and thigh pain began two weeks earlier. Dr. Ihm then commented that the records of Dr. Haak revealed that the petitioner had been experiencing low back and thigh pain for approximately one year. The petitioner then admitted to Dr. Ihm that he had experienced pain for approximately one year, but that it had worsened in the past two weeks. The petitioner then changed his statement and indicated that five days before [May 14, 2009] he pulled a toilet at work and his pain increased causing him to go to the emergency room. (PX 15). The petitioner advised Dr. Ihm that he had been off of work since May 14, 2009. (PX 15). Dr. Ihm testified that the petitioner did not report work injuries occurring in March 2009 or in August 2008. (RX 8, p.24-25).

Based on his review of the petitioner's March 6, 2009 lumbar MRI scan, Dr. Ihm agreed with Dr. Haak's recommendations for treatment. Accordingly, the petitioner was referred for epidural steroid injections and physical therapy and was provided with an updated prescription for Norco. (PX 15). Dr. Ihm authorized the petitioner off of work until June 9, 2009. (PX 15).

Dr. Christopher Plastaras performed a left L3-4 transforaminal epidural steroid injection on May 22, 2009. (PX 15, p.79). The petitioner then began physical therapy at the Rehabilitation Institute of Chicago on May 28, 2009. (PX 13). The petitioner retuned to Dr. Ihm on June 9, 2009, reporting improvement in his low back and a resolution of his leg pain since the injection. (PX 15). Dr. Ihm therefore released the petitioner to return to work with restrictions and recommended continued physical therapy. (PX 15).

The petitioner returned to work with light duty restrictions as of June 9, 2009. He then returned to Dr. Ihm on June 19, 2009 with complaints of pain. Dr. Ihm authorized the petitioner off of work until July 6, 2009 and recommended continued physical therapy. (PX 15). The petitioner attended therapy through July 1, 2009. The July 1, 2009 therapy report indicates that the petitioner reported improvement in his low back pain and a resolution of his leg pain since beginning therapy. (PX 13).

On July 6, 2009, the petitioner returned to work. He was then reevaluated by Dr. Ihm on July 13, 2009. The petitioner reported 50% improvement and a resolution of his leg pain. Dr. Ihm recommended a left zygapophysial joint injection at L5-S1, continued physical therapy, and work restrictions. (PX 15).

Despite Dr. Ihm's recommendation for ongoing physical therapy, the petitioner did not return to therapy after July 1, 2009. On August 6, 2009, the petitioner underwent a left zygapophysial joint injection at L5-S1. (PX 15). The petitioner continued working and returned to Dr. Ihm on August 26, 2009. At that point, Dr. Ihm noted that the petitioner had experienced some relief following the L5-S1 zygapophysial joint injection. Thus, it was recommended that the petitioner undergo a left medial branch block at L5-S1. (PX 15).

The left medical branch block was performed at L4 and L5 on September 10, 2009. (PX 13). The petitioner returned to Dr. Ihm on September 21, 2009 reporting no improvement since the block. While Dr. Ihm suggested another injection, the petitioner requested a consultation with Dr. Haak before proceeding. . (PX 15).

The petitioner testified that he continued working for the respondent. (TX 7/31/13 p.61). On October 7, 2009, the petitioner filed two Applications for Adjustment of Claim. (Arb. 2). The first Application, corresponding with case number 09 WC 41911, alleges an injury sustained on March 5, 2009 while mopping a floor at work. The second Application, corresponding with case number 09 WC 41912, alleges an injury sustained on May 14, 2009 while pulling a toilet seat at work.

Both the petitioner and the respondent entered medical records obtained from the office of Dr. Michael Haak into evidence at the time of trial. The medical records of Dr. Haak generated in response to a subpoenaed issued on July 6, 2011 were entered into evidence by the petitioner. (PX 14). The medical records of Dr. Haak generated in response to a subpoena issued on April 1, 2010 were entered into evidence by the respondent. (RX 2). The two sets of records differ from one another as outlined below.

The petitioner returned to Dr. Haak for a reevaluation on October 27, 2009. (PX 14, p. 15). The petitioner was complaining mainly of left leg pain with only a small degree of low back pain. Based on the March 6, 2009 MRI scan, Dr. Haak diagnosed multilevel degenerative disc disease with left-sided foraminal narrowing primarily at L3-4 and L5-S1. Given the petitioner's symptoms, it was recommended that the petitioner undergo a left sided laminotomy and foraminotomy at L3-4 and L5-S1. (PX 14, p.10). In the interim, the petitioner testified that he continued working for the respondent. (TX 7/31/13 p.61).

Due to a death in the family, the petitioner's surgery was postponed. (PX 14, p.24). He returned to Dr. Haak on November 24, 2009. At that point, Dr. Haak noted that the petitioner was "still symptomatic because of his underlying problems, primarily at L3-4 and L5-S1." (PX 14, p.24; RX 2). Dr. Haak's report indicates that the petitioner was scheduled to undergo pre-operative testing at the end of December 2009. The petitioner was then to return to see Dr. Haak at the beginning of January 2010 to review the testing and surgery recommendations. (PX 14, p.24; RX 2).

As noted above, the medical records of Dr. Haak generated in response to a subpoenaed issued on July 6, 2011 were entered into evidence by the petitioner. (PX 14). These records contain a December 8, 2009 report. At the time of his deposition, Dr. Haak testified that this report was added to the petitioner's chart on February 7, 2011. Specifically, on February 7, 2011 at 5:53pm he added an "Addendum" to his December 8, 2009 report, including a statement regarding the petitioner's alleged injury while working pulling a toilet. (RX 3, p.37-39; PX 14, p.29). Dr. Haak testified that he did not know what caused him to open his chart notes on February 7, 2011, over one year after the December 8, 2009 visit, to amend the record to include this report of accident. (RX 3, p.39). The medical records provided by Dr. Haak's office in response to a subpoena issued on April 5, 2010 do not contain the December 8, 2009 report or the February 7, 2011 addendum regarding a work accident. (RX 2).

Both Petitioner's Exhibit 14 and Respondent's Exhibit 2 indicate that the petitioner did return to Dr. Haak as scheduled for pre-operative clearance on January 12, 2010. (RX 2; PX 14, p.35). The corresponding report, which was not re-opened and amended on February 7, 2011, indicates that the petitioner was symptomatic due to his underlying degenerative disc disease and foraminal stenosis. As such, Dr. Haak reaffirmed the recommendation for a left sided laminotomy and foraminotomy at L3-4 and L5-S1. (RX 2; PX 14, p.35).

On January 15, 2010 Dr. Haak performed a left L5-S1 hemilaminotomy and foraminotomy. (RX 2). Following surgery, the petitioner was admitted to the hospital until January 17, 2010. As per Respondent's Exhibit 2, post operatively, the petitioner was seen by Dr. Haak's nurse on January 27, 2010 and again on February 23, 2010. The February 23, 2010 notation contained in Respondent's Exhibit 2, indicates that at that time, the petitioner was provided with a refill of Norco and was referred for post-operative physical therapy. (RX 2). The February 23, 2010, notation contained in Petitioner's Exhibit 14, however, contains an "Addendum" added by Dr. Haak one year later on February 7, 2011. The "Addendum" notes incorrectly that the petitioner had lumbar surgery on December 7, 2009. Further, the "Addendum" notes that the petitioner's original back pains "came on after he was working on a toilet." (PX 14, p.45). This "Addendum" is not contained in the records of Dr. Haak provided via subpoena issued on April 1, 2010. (RX 2).

As per the recommendation of Dr. Haak, the petitioner presented to Flexeon Rehabilitation for post-operative physical therapy on March 2, 2010. (PX 12). Upon presentation, the petitioner reported that he had initially injured his low back on March 5, 2009 when he was pulling a toilet off the floor. (PX 12). It was noted that the petitioner had since undergone a laminectomy and foraminotomy, following which he had been referred for post-operative physical therapy. Based on the petitioner's physical examination and as per the recommendations of Dr. Haak, the petitioner was scheduled for therapy two to three times per week for four weeks. (PX 12).

After beginning physical therapy, the petitioner returned to Dr. Haak on March 23, 2010. (PX 14, p.52; RX 2). The petitioner reported continued low back pain with some radiation into the left buttock. It was recommended that he continue therapy for an additional four weeks and remain off of work in the interim.

The petitioner was seen by Dr. Haak for a follow up appointment on April 29, 2010. As per Petitioner's Exhibit 14, on May 1, 2010, Dr. Haak added an "Addendum" to the report corresponding with the April 29, 2010 evaluation. (PX 14, p.58). As per the "Addendum" report, the petitioner reported improvement in his low back pain since undergoing surgical treatment. Dr. Haak recommended continued therapy, provided refills of pain medication, and authorized the petitioner off of work. This "Addendum," added just two days after the office visit, does not contain a report of a work related injury. (PX 14, p.58-59).

At the respondent's request and pursuant to Section12, the petitioner underwent an examination with Dr. Kern Singh on February 15, 2010. Dr. Singh's evidence deposition was taken on June 24, 2010. The petitioner, his wife, and the petitioner's attorney were present at the time of the deposition. Dr. Singh testified that upon presentation, the petitioner completed an intake questionnaire. (RX1, Ex 2). In this questionnaire, the petitioner reported that his low back pain had begun on March 5, 2009. He specifically denied any similar problems having

occurred prior to March 5, 2009. (RX 1, Ex 2). The petitioner advised Dr. Singh that he initially injured his low back on March 5, 2009 when he was attempting to move a toilet at work. (RX 1, p.11). The petitioner advised that he then injured his back a second time on May 14, 2009 while mopping a floor. (RX 1, p.11).

Dr. Singh testified that in conjunction with his examination of the petitioner he reviewed the medical treatment records of Dr. Evan Lu and Dr. Michael Haak, as well as the films corresponding with the March 6, 2009 lumbar MRI scan. (RX 1, p.9, 11). Dr. Singh noted that the petitioner initially reported low back and leg pain to Dr. Lu in August 2008. (RX 1, p.45-46). Dr. Singh opined that the March 6, 2009 MRI films revealed a degenerative process without any evidence of an acute injury having occurred the day before, on March 5, 2009. (RX 1, p.12-13). Based on the medical records revealing treatment beginning in August 2008, and given the MRI films, Dr. Singh opined that the petitioner's condition was causally connected to a chronic degenerative process rather than work accidents occurring on either March 5, 2009 or May 14, 2009. (RX 1, p.16, 45-46).

After the June 24, 2010 deposition of Dr. Singh, on July 9, 2010, the petitioner filed a third Application for Adjustment of Claim at the Commission. This third Application, corresponding with case number 10 WC 26667, alleges that the petitioner sustained an injury to his low back on August 8, 2008 while bending down to rod a sink at work. (Arb. 2).

When the petitioner returned to Dr. Haak on July 20, 2010, he reported improvement in his pain level. (PX 14, p. 71). As of July 26, 2010, Dr. Haak released the petitioner to return to work with light duty restrictions. Dr. Haak authored a "To Whom It May Concern" letter to this regard on July 26, 2010, outlining the petitioner's light duty restrictions. (RX 3, Ex. 14). Dr. Haak testified that such "To Whom It May Concern" letters are generated by his office only in cases involving patients with non-occupational injuries. (RX 3, p.55-56). This "To Whom It May Concern" letter was entered into evidence by the respondent at the time of Dr. Haak's deposition; however, the letter is not included in the transcript of the deposition offered at the time of trial by the petitioner. It is included in the deposition transcript of Dr. Haak entered into evidence by the respondent at the time of trial. (RX 3, Ex. 14; PX 10).

The petitioner returned to Dr. Haak on August 31, 2010. The corresponding office visit note was edited six months later by Dr. Haak on February 7, 2011 when an "Addendum" was added at 5:58pm. (PX 14, p.77, RX 3, p.52). The report indicates that when seen on August 31, 2010, the petitioner reported minimal low back pain and no leg pain. The petitioner had improved range of motion of the low back, which Dr. Haak considered age appropriate. Dr. Haak noted that prior to the incident that occurred while pulling a toilet at work the petitioner did not have any significant back or leg pain issues. Because the petitioner did not have any significant back or leg pain, as of August 31, 2010, Dr. Haak released him to return to work at full duty. It was recommended that the petitioner return for an evaluation in four months. (PX 14, p.77).

The final office visit with Dr. Haak took place on November 16, 2010. (PX 14, p.84). The petitioner reported some occasional low back pain yet overall had good range of motion and equal, symmetric strength in his lower extremities. Dr. Haak released the petitioner from treatment and opined that the petitioner was capable of returning to work at full duty at that time.

(PX 14, p.84). The petitioner has not undergone any medical treatment in relation to the low back since November 16, 2010.

After being released to full duty, the petitioner did not return to work for the respondent. Ms. Katherine Paul, who was employed as the Vice President of Human Resources at the time of the alleged accidents, testified on behalf of the respondent at the time of trial. Ms. Paul testified that the petitioner was terminated by the respondent in August 2010 when the Habitat Company lost the contract to manage the York Terrace Apartments, the particular building in which the petitioner was working. (TX 2/28/14, p.55-56).

Ms. Paul testified that under the petitioner's union contract, union employees stay employed by the property at which they work, not with the property management company that holds the management contract. Therefore, when a building changes property management companies, the employees at the given location become employees of the new property management company as per the union contract. (TX 2/28/14, p.56). After management of the York Terrace Apartments was transferred to another property management company during the summer of 2010, the employees working at the York Terrace were terminated by the respondent and were absorbed by the new property management company as per the union agreement. (TX 2/28/14, p.57).

CONCLUSIONS OF LAW

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

An injury arises out of one's employment if it has its' origin in a risk that is connected to or incidental to the employment so that there is a causal connection between the employment and the accidental injury. *Technical Tape Corp. vs IndustrialCommission,* 58 Ill. 2d 226, 317 N.E.2d 515 (1974) "Arising out of' is primarily concerned with the causal connection to the employment. The majority of cases look for facts that establish or demonstrate an increased risk to which the employee is subjected to by the situation as compared to the risk that the general public is exposed to.

An employer's liability for benefits cannot be based on guess, speculation or conjecture. *Illinois Bell Telephone* v. *Industrial Commission*, 265 Ill.App.3d 681, 638 N.E.2d 207 (1994).

Longstanding Illinois law mandates a claimant must show that the injury is due to a cause connected to the employment to establish it arose out of employment. *Elliot v. Industrial Commission*, 153 Ill. App. 3d 238, 242 (1987). The burden of proof is on a claimant to establish the elements of his right to compensation, and unless the evidence considered in its entirety supports a finding that the injury resulted from a cause connected with the employment, there is no right to recover. *Board of Trustees v. Industrial Commission*, 44 Ill. 2d 214 (1969).

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,* 71 Ill.2d 368, 375 N.E.2d 1306 (1978)

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

Was timely notice of the accident given to Respondent?

Is the petitioner's present condition of ill-being causally related to the injury?

It is axiomatic that the petitioner bears the burden of proving all the elements of his claim by a preponderance of the credible evidence. Based on the totality of the credible evidence, the Arbitrator finds that the petitioner failed to meet that burden here. Specifically, the Arbitrator finds, as a matter of fact and conclusion of law, that the petitioner failed to prove accidental injuries occurred which arose out of and in the course of the petitioner's employment with the respondent and failed to prove a causal relationship between his current condition of ill-being and his employment with the respondent.

The Arbitrator notes that on October 7, 2009, the petitioner filed two Applications for Adjustment of Claim. The first Application alleges an injury sustained on March 5, 2009 while mopping a floor and the second Application alleges an injury sustained on May 14, 2009 while pulling a toilet. Then, on July 9, 2010, approximately one year after filing the initial Applications, the petitioner filed a third Application for Adjustment of Claim alleging an injury sustained on August 8, 2008 while rodding a sink.

August 8, 2008 alleged accident:

The Arbitrator will first address the alleged August 8, 2008 accident. In looking at the totality of the medical treatment records, there is no mention whatsoever of an accident having occurred on August 8, 2008 while rodding a sink. The medical records of Dr. Evan Lu reveal that the petitioner began treatment on August 11, 2008, for complaints of low back and left leg pain. (RX 9, p.85). The corresponding office visit report does not contain any mention whatsoever of an accident having occurred at work three days earlier when the petitioner was rodding a sink. In fact, the record indicates that the petitioner specifically denied any history of trauma associated with the symptoms. (RX 9, p.90). On November 10, 2008, the petitioner returned to Dr. Lu and was again provided with a prescription for Norco for sciatica and low back pain. (RX 9). The medical records corresponding with the November 10, 2008 office visit do not contain any reference to a work related injury or history of trauma.

The petitioner continued to treat for low back pain and sciatica through February 2009. The petitioner testified that he returned to Dr. Lu on February 28, 2009 with complaints of low back and bilateral leg pain. (TX 7/31/13 p.50; RX 9). The petitioner did not report a history or work injury or trauma associated with the symptoms. (RX 9). Given the duration of his symptoms, Dr. Lu referred the petitioner for a lumbar MRI scan and an orthopedic consultation at the Northwestern Memorial Faculty Foundation. (RX 9, p.112).

As outlined in the Findings of Fact, the petitioner then went on to treat with Dr. Michael Haak, Northwestern Memorial Hospital, Dr. Joseph Ihm and RIC, and Flexeon Rehabilitation. In addition, the petitioner was examined by Dr. Kern Singh at the request of the respondent pursuant to Section 12. None of the records of any of these providers contain any report whatsoever of an accident having occurred at work on August 8, 2008.

In fact, there was no mention whatsoever of this alleged accident until after the evidence deposition of Dr. Kern Singh was taken. The petitioner underwent an examination with Dr. Singh on February 15, 2010 in accordance with Section 12. Following the IME, the evidence deposition of Dr. Singh was taken on June 24, 2010. (RX 1). At the time of the IME and subsequent deposition, the only Applications for Adjustment of Claim that had been filed on behalf of the petitioner corresponded with the alleged March 5, 2009 and May 14, 2009 dates of loss. At the time of the deposition of Dr. Singh, the petitioner only referenced alleged accidents occurring in March 2009 and May 2009.

There is no mention of an August 8, 2008 accident contained in the transcript of the deposition of Dr. Singh. (RX 1). The petitioner, the petitioner's wife, and the petitioner's attorney were present at this June 24, 2010 evidence deposition. Dr. Singh testified that the before the exam began, the petitioner completed an intake questionnaire. (RX1, Ex 2). In this questionnaire, the petitioner wrote that his symptoms began on March 5, 2009. The petitioner specifically denied any similar problems having occurred prior to March 5, 2009. (RX 1, Ex 2). Dr. Singh testified that the petitioner reported that his condition began on March 5, 2009 when he was attempting to move a toilet at work and that it was then further aggravated on May 14, 2009 while mopping a floor. (RX 1, p.11). Based on his review of the medical records, however, Dr. Singh testified that the petitioner's condition was caused by a chronic degenerative process rather than the alleged March 5, 2009 or May 14, 2009 accidents. (RX 1, p.15). In support of his opinion, Dr. Singh cited the medical records of Dr. Evan Lu, noting that the petitioner first sought treatment for low back and leg pain in 2008. (RX 1, p.45-46).

After Dr. Singh testified that the petitioner's condition was evident as early as August 2008, the petitioner filed a third Application for Adjustment of Claim at the Commission. Specifically, approximately two weeks after the deposition of Dr. Singh was taken, on July 9, 2010 the petitioner filed a third Application, corresponding with case number 10 WC 26667, alleging that he sustained an injury to his low back on August 8, 2008 while bending down to rod a sink at work. (Arb. 1). This Application was clearly filed in direct response to the testimony of Dr. Singh. There was no mention of said work accident anywhere in the records and there was no mention of any such work accident at the time of the deposition of Dr. Singh.

Given the lack any supporting evidence, the Arbitrator finds that the petitioner did not sustain an accident arising out of or in the course of his employment with respondent on August 8, 2008. As such, the petitioner's condition of ill-being is not causally related to an August 8, 2008 accident.

March 5, 2009 and May 14, 2009 Alleged Accidents:

The Arbitrator will next address the alleged March 5, 2009 and May 14, 2009 accidents. As per Arbitrator's Exhibit 1, the petitioner alleges to have sustained injuries to his low back on March 5, 2009 while mopping a floor, and again on May 14, 2009 while pulling a toilet. Based

on the treatment records and the testimony provided at trial as outlined below, the Arbitrator finds that the petitioner failed to establish that he sustained accidents arising out of and in the course of his employment with the respondent on either March 5, 2009 or May 14, 2009.

Accordingly, the petitioner's condition of ill-being is not causally related to any such accidents, but rather is directly related to a chronic degenerative process.

Despite the petitioner's allegation of a March 5, 2009 accident causing his low back and leg symptoms, the medical records detail extensive treatment prior to any such accident. As per Dr. Lu's February 28, 2009 recommendation, the petitioner's complaints had progressed to a point where he had been scheduled to undergo a lumbar MRI scan. The lumbar MRI scan, which took place on March 6, 2009, was scheduled a week in advance of the alleged March 5, 2009 accident.

The records corresponding with the March 6, 2009 MRI scan, taken only one day after the alleged accident, do not contain any report of a work accident having occurred on March 5, 2009 while mopping a floor at work. The March 6, 2009 MRI scan revealed multilevel degenerative changes consistent with a chronic degenerative condition. (RX 9). Dr. Singh testified that the MRI did not reveal any evidence of an acute trauma having occurred the day before the scan was taken and Dr. Haak, the petitioner's own treating surgeon, admitted that the findings on the March 6, 2009 MRI scan could not have developed overnight. (RX1, p.12; RX 3, p.28-29). Further, Dr. Haak testified that he based his surgical recommendations on the petitioner's complaints of pain and the findings contained in that MRI scan, which pre-dated the alleged March 5, 2009 accident. (RX 3, p.29).

After the MRI scan was completed, the petitioner returned to Dr. Lu for a follow up on April 15, 2009. (RX 9, p.135). Despite the petitioner's allegation of an accident having occurred at work approximately one month before, the corresponding record contains no mention whatsoever of a March 5, 2009 accident. The petitioner was advised to follow up with orthopedics as scheduled. (RX 9, p.135.)

Similarly, the initial (or any subsequent) medical records of Dr. Michael Haak do not contain any reference to the alleged March 5, 2009 accident. As recommended, the petitioner presented to Dr. Michael Haak at the Northwestern Memorial Faculty Foundation on April 21, 2009. (PX 14). The petitioner testified that when he presented to Dr. Haak on April 21, 2009, he completed a "New Patient Profile" questionnaire. (TX 7/31/13 p.51). The petitioner testified that he completed this form truthfully. (TX 7/31/13 p.51). The "New Patient Profile" questionnaire, a copy of which is contained in the medical records of Dr. Haak entered into evidence by the petitioner, indicates that the petitioner reported that his pain began one year earlier; that he began taking medication for pain in March 2009, and that Dr. Lu had since referred him to Dr. Haak for an evaluation. (PX 14, p.11). The petitioner did not inform Dr. Haak that he had actually been taking pain medication for low back and leg pain since August of 2008. Dr. Haak's April 21, 2009 report does not indicate any report of work accidents as having occurred on August 8, 2008 or March 5, 2009. (PX 14, p.11).

Rather, the April 21, 2009 office visit note indicates that the petitioner's symptoms of back and thigh pain had begun approximately one year earlier and had become more severe within the two months before the evaluation. (PX 14, p.9-10). Following an examination and

review of the March 6, 2009 MRI scan, Dr. Haak diagnosed lumbar degenerative disc disease, lumbar radiculopathy, and lumbago. (PX 14, p.9-10). Dr. Haak opined that the petitioner was "symptomatic because of his underlying degenerative disc disease." (PX 14, p.10). At that point, as of April 21, 2009, Dr. Haak referred the petitioner to Dr. Joseph Ihm of the Center for Spine, Sports and Occupational Rehabilitation of the RIC for epidural steroid injections and physical therapy. (PX 14, p.10).

Following the initial visit with Dr. Haak, the petitioner was seen at Northwestern Memorial Hospital's emergency room on May 14, 2009. While the petitioner alleges to have sustained an accident at work on that very day, the corresponding medical records do not contain any reference whatsoever of an accident having occurred on May 14, 2009 or on March 5, 2009. The medical records generated by Northwestern Memorial Hospital's emergency room on May 14, 2009 indicate that the petitioner presented to the emergency room at 8:47am with complaints of lower back pain with radiation into the left leg. Not only is there no mention of an accident having occurred at work earlier that day, but the report also indicates that the petitioner's pain had begun the night before and had been so intense that he had been unable to work on May 14, 2009 and had therefore gone to the emergency room. The record indicates that the petitioner specifically *denied any trauma* associated with the symptoms. (PX 17).

After being discharged from the emergency room with a diagnosis of low back pain, as per Dr. Haak's April 21, 2009 recommendation, the petitioner presented for an evaluation with Dr. Joseph Ihm on May 19, 2009. The corresponding office visit record contains a questionable report on the part of the petitioner regarding the alleged May 14, 2009 accident. At the time of his deposition, Dr. Ihm testified that the petitioner did not report work injuries occurring in March 2009 or August 2008. (RX 8, p.24-25). The May 19, 2009 medical report indicates that when initially asked about the cause of his symptoms, the petitioner first tried to tell Dr. Ihm that his low back and leg pain began two weeks earlier. Dr. Ihm then questioned the petitioner about this statement, given that the records of Dr. Haak indicate that the petitioner had been experiencing low back and thigh pain for approximately one year. Only then did the petitioner admit that he had experienced pain for approximately one year, but he went on to allege that it had worsened in the past two weeks. (PX 15). When further questioned by Dr. Ihm, the petitioner then changed his statement again and alleged that five days before [May 14, 2009] he pulled a toilet at work and his pain increased causing him to go to the emergency room. (PX 15).

This statement is wholly inconsistent with the May 14, 2009 medical records of Northwestern Memorial Hospital's emergency room, which do not contain any mention whatsoever of a work injury as having occurred that very day. Again, the May 14, 2009 emergency room records specifically deny any trauma or accident and indicate that the petitioner reported that his pain had increased at home the night before and that he had been unable to work on May 14, 2009 because of the pain. (PX 17).

After undergoing treatment with Dr. Ihm, the petitioner returned to treatment with Dr. Haak. As noted in the Findings of Fact above, both the petitioner and the respondent entered medical records obtained via subpoena from the office of Dr. Michael Haak into evidence at the time of trial. The medical records of Dr. Haak generated in response to a subpoenaed issued on July 6, 2011 were entered into evidence by the petitioner. (PX 14). The medical records of Dr. Haak generated in response to a subpoena issued on April 1, 2010 were entered into evidence by the respondent. (RX 2). The Arbitrator notes that the two sets of medical records differ

significantly from one another. For this reason, and as outlined below, the Arbitrator questions the credibility of Dr. Haak.

As per Respondent's Exhibit 2, the petitioner returned to Dr. Haak for a reevaluation on October 27, 2009. The corresponding report contains no mention or any history of work accident or trauma. (RX 2). Based on the March 6, 2009 MRI scan, Dr. Haak diagnosed multilevel degenerative disc disease with left-sided foraminal narrowing primarily at L3-4 and L5-S1. Given the petitioner's symptoms, he was recommended for a left sided laminotomy and foraminotomy at L3-4 and L5-S1. (RX 2).

Again, as per Respondent's Exhibit 2, the petitioner returned to Dr. Haak on November 24, 2009 at which point it was noted that his surgery had been postponed until January 2010 due to a death in the family. (RX 2). Dr. Haak noted that the petitioner was "still symptomatic because of his underlying problems, primarily at L3-4 and L5-S1." (PX 14, p.24; RX 2). Dr. Haak's report indicates that the petitioner was scheduled to undergo pre-operative testing at the end of December 2009 and he was then to return to see Dr. Haak at the beginning of January 2010 to review the testing and surgery recommendations. (RX 2).

After this point, Respondent's Exhibit 2, the medical records of Dr. Haak generated via subpoena on April 1, 2010, begin to differ from those generated in response to a subpoena issued on July 6, 2011, which were entered into evidence by the petitioner as Petitioner's Exhibit 14. (PX 14).

Petitioner's Exhibit 14 contains several medical records which were retroactively amended by Dr. Haak on February 7, 2011 between 5:38pm and 5:58pm. These "Addendums" were added to three office visit notes corresponding with treatment provided on December 8, 2009, February 23, 2010, and August 31, 2010. The "Addendums" included in the December 8, 2009 and February 23, 2010 office visit notes state "his original pains came on after he was working on a toilet and he had relatively severe back and leg pain." (PX 14, p.29, 45). The "Addendum" added to the August 31, 2010 medical record notes, "his original injury occurred when he was pulling a toilet at work and he had the onset of relatively severe back and leg pain problems. Prior to that he had not been having any difficulties and had not had any significant back and leg pain issues while he was working at the job." (PX 14, p.77). None of the "Addendums" include a date of the alleged injury involving the toilet. None of the "Addendums" refer to the alleged accidents involving rodding a sink or mopping the floor

Before these "Addendums" were added to the petitioner's medical records on February 7, 2011, the records of Dr. Haak did not contain any reference whatsoever to any of the three alleged work accidents. Both Petitioner's Exhibit 14 and Respondent's Exhibit 2 reveal that the ten office visit reports which were not amended on February 7, 2011 do not contain any reference to a work accident. The un-amended records indicate that the petitioner was "symptomatic due to his underlying degenerative disc disease and foraminal stenosis." (RX 2; PX 14, p.35).

At the time of his deposition, Dr. Haak testified that he last saw the petitioner on November 16, 2010. Dr. Haak admitted that on February 7, 2011, three months after this last office visit, he went into the petitioner's medical records and added the "Addendums," which contain the only mentions of a work accident in his records. (RX 3, p.38-40). Dr. Haak could not

recall why he went into the petitioner's medical records months after treatment was complete to change three reports in such a material way. (RX 3, p.38-40).

Not only did Dr. Haak's original records not contain any report of a work related injury, but Dr. Haak also testified that he issued a report for the petitioner in accordance with his protocol for non-occupational injuries. (RX 3, p.55-57). Dr. Haak testified that for non-occupational cases he issues "To Whom It May Concern" letters outlining a diagnosis and recommendations for care along with work restrictions. (RX 3, p.56). Dr. Haak testified that these "To Whom It May Concern" letters differ from work status notes generated in workers' compensation cases, which are standard, pre-printed forms, directed to the insurance company. (RX 3, p.55-56). Dr. Haak testified that in this case, he issued a "To Whom It May Concern" letter on July 26, 2010, which would be consistent with such letters generated in non-occupational cases. (RX 3, p.56, H14). The records of Dr. Haak contain no standard, pre-pre-printed work status notes directed to the insurance company such as those generated in workers' compensation cases.

At the time of the deposition, Dr. Haak testified extensively regarding the July 26, 2010 non-occupational "To Whom It May Concern" letter which he issued. At the conclusion of the deposition, the respondent offered the July 26, 2010 "To Whom It May Concern" letter, labeled as "H14," into evidence. (RX 2, p.57, H14).

The Arbitrator notes that the copy of the evidence deposition of Dr. Haak offered into evidence by the respondent includes all of the deposition exhibits offered at the conclusion of Dr. Haak's testimony, including "H14." (RX 3).

While the "Addendums" contained in the medical records of Dr. Haak indicate that the petitioner was injured while pulling a toilet, the records of Dr. Haak do not contain a specific date on which this toilet incident allegedly occurred. The petitioner's own recollections of the dates and corresponding accidents are also inconsistent. On October 7, 2009, the petitioner filed Applications alleging injuries on March 5, 2009 while mopping a floor and on May 14, 2009 while pulling a toilet. Then, on December 22, 2009, the petitioner filed two Petitions for Immediate Hearing under Section 19(b) of the Act at the Commission, the first Petition alleging an injury sustained on March 5, 2009 while pulling a toilet seat, and the second Petition alleging an injury sustained on May 14, 2009 while mopping. (RX 6). The subsequent reports of Dr. Singh and Flexeon Rehabilitation reiterate that the petitioner reported to the providers that the March 5, 2009 accident involved pulling a toilet at work. (PX 12; RX 1, p.11). When questioned about the accidents on cross examination, the petitioner was unable to recall specifically what accident happened on which date. (TX 7/31/13, p.81-89). As such, the Arbitrator finds the petitioner's own reports of accident to be unreliable.

The Arbitrator's findings regarding accident and notice are also supported by the credible testimony of Ms. Katherine Paul, the Vice President of Human Resources for the respondent at the time of the alleged accidents. As per Ms. Paul's testimony, the petitioner was aware of the process and protocol for reporting work accidents as every employee of the respondent was required to take an OSHA training and workers' compensation training class each year. (TX 2/28/14, p.42). This protocol mandates that an accident be immediately reported to a supervisor, who then contacts the respondent's workers' compensation insurance administrator, who then records the incident in the computer system. (TX 2/28/14, p. 41-42). The accident is recorded in

the system immediately upon notification and is then reported directly to Ms. Paul. (TX 2/28/14, p.43-44). Ms. Paul testified that her records and the petitioner's electronic file documentation did not contain any reports of work accidents having occurred on March 5, 2009 or May 14, 2009. The only notation of the August 8, 2008 accident was made in 2010 after the respondent received notification of the filing of the Application for Adjustment of Claim in July 2010. No reports of accident were actually made in 2008 in that regard. (TX 2/28/14, p.46-47).

Based on the forgoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the petitioner failed to establish that he sustained an accident arising out of and in the course of his employment. In addition, the Arbitrator finds that the petitioner failed to prove that his current condition of ill-being is causally connected to any work related injury.

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?

What amount of compensation is due for temporary total disability and maintenance benefits?

What is the nature and extent of the injury?

In light of the Arbitrator's findings on issues of accident, notice and causal connection above, determination of the remaining disputed issues is moot. The Petitioner failed to prove that he sustained accidental injuries that arose out of and in the course of his employment and that his current condition of ill-being is related to an accident that arose out of and in the course of his employment, no benefits are awarded

Should penalties and fees be imposed upon Respondent?

The petitioner filed a Petition for Penalties claiming that penalties under Sections 19(k), 19(l) and Attorney's fees under Section 16 should be awarded. The Petition is denied. Section 19(k) penalties are imposed where there has been an unreasonable or vexatious delay in payment of compensation, or proceedings have been instituted by the employer which are frivolous or for purpose of delay. *Boker v. Illinois Industrial Comm'n*, 141 Ill.App.3d 51, 56 (Ill. App. Ct. 3rd Dist. 1986). "The additional compensation authorized by section 19(l) is in the nature of a late fee. The statute applies whenever the employer or its carrier simply fails, neglects, or refuses to make payment or unreasonably delays payment "without good and just cause." 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 the statutorily specified additional compensation is mandatory." *McMahan v. Industrial Commission*, 183 Ill.2d 499, 702 N.E.2d 545 (1998).

Section 16 fees are awarded where an employer has engaged in unreasonable or vexatious delay, intentional underpayment, or frivolous defenses under Section 19(k). *Boker*, 141 Ill.App.3d at 55. Unlike other penalties under the Act that are mandatory, the award of substantial penalties under Section 19(k) and attorney's fees under Section 16 is discretionary. *McMahan v. Industrial Comm'n*, 183 Ill.2d 499, 515 (1998).

The Illinois Supreme Court, in *McMahan*, noted that the imposition of Section 19(k) and Section 16 attorney's fees requires a higher standard than an award of additional compensation under Section 19(l). *McMahan*, 183 Ill.2d 499at 514 (1998). Further, the Court noted that Section 19(k) and 19(l) penalties were intended to address different situations, with Section 19(k) providing substantial penalties, imposition of which are discretionary, rather than mandatory. *McMahan*, 183 Ill.2d at 515 (1998). Section 16 includes language identical to the language in Section 19(k), and it was intended to apply in the same type of circumstances. *McMahan v. Industrial Comm'n*, 183 Ill.2d 499 at 515 (1998).

In this case, the respondent acted neither unreasonably or vexatiously. The Arbitrator finds that the respondent's reliance upon the opinion of Dr. Kern Singh following February 15, 2010 independent medical evaluation was reasonable. The Arbitrator notes that the medical records of the treating physician, Dr. Lu, do not contain any causal connection opinions or reports of accident. Further, the medical records of Dr. Haak did not contain any such reports of accident until they were amended by the doctor for an unknown reason in February 2011. Therefore, the Arbitrator denies the claims for penalties and fees.

ORDER OF THE ARBITRATOR

The Petitioner failed to prove a compensable accident within the meaning of the Act. Benefits requested pursuant to Section 8 are therefore denied.

Deborah L. Simpson
Signature of Arbitrator

Aug 19, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

RONALD KNEZEVICH,

Petitioner,

vs.

NO: 06 WC 47052

MARTIN CEMENT COMPANY,

15IWCC0626

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, average weekly wage (AWW), medical, temporary total disability (TTD), penalties, maintenance, and permanent partial disability (PPD), and being advised of the facts and applicable law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

So that the record is clear, and there is no mistake as to the intentions or actions of the Commission, we have considered the record in its entirety. We have reviewed the facts of the matter, both from a legal and a medical/legal perspective. The Commission has considered all of the testimony, exhibits, pleadings and arguments submitted by the parties.

The Commission finds Petitioner failed to prove that he is permanently and totally disabled as a result of his work-related injury of August 14, 2006. The Commission finds Petitioner reached maximum medical improvement (MMI) as of July 14, 2011, the date of Dr. Avi Bernstein's evidence deposition. The Petitioner is entitled to TTD benefits and medical expenses through the date of MMI. The Commission finds Petitioner is entitled to 25% man-as-a-whole pursuant to Section 8(d)(2) of the Act.

Mr. Knezevich has worked as an Iron Worker out of Local 444 off and on since 1972. He

worked 2,985 hours between 2003 and 2006. This amounts to just over 500 hours of work per year.

According to Respondent's exhibit 1, A Judgment for Dissolution of Marriage was entered on August 15, 1996 indicating Mr. Knezevich was currently unemployed and receiving social security disability benefits. RX.1.

Petitioner applied for a trial work program in September 21, 1996. Mr. Knezevich certified that he was receiving social security disability benefits. PX.16. Petitioner testified that this program allowed him to go back to work as an iron worker and remain on social security disability for 9 months. After the 9 months, he returned to work full-duty. T.63. He worked as an iron worker from 1996 to 1999 with no restrictions. T.97 –T.98.

Petitioner sustained an injury on October 21, 1999 to both shoulders and both knees resulting in two rotator cuff repair surgeries. Petitioner underwent an FCE on November 8, 2000. The FCE revealed that Petitioner could not return to work as an iron worker as it was classified as heavy duty work. He was unable to sustain work at the medium physical demand level and should remain in a light to medium demand level. He was advised to seek alternative employment. RX.5. He was completely off work between 1999 and the 2003.

Petitioner entered into a lump sum settlement contract on April 16, 2003 for injuries sustained as a result of the October 21, 1999 injury. The settlement amount was $194,827.60, representing $508.72 per month over his remaining 28.5 years of life expectancy. The settlement was a disputed payout pursuant to Section 8(f) of the Act. RX.4. Petitioner testified and the contract stated that he was unable to return to work as an Iron Worker.

Petitioner returned to work as an iron worker a month or two after the settlement in 2003. T.102. Petitioner testified that he was able to return to work, following his 2003 settlement, by going through extensive therapy and exercise. He built his shoulder and back up to the point he could handle the duties of an iron worker. T.38. He also went back to work because he did not want to be a "dole" on society. T.37

Dr. Komanduri released Petitioner from his care on April 9, 2003. According to Dr. Komanduri's record, Petitioner had full range of motion of the right shoulder with good strength. PX.14. Dr. Komanduri testified that he was released to full duty as an iron worker as he had no complaints. PX.14. pg.10. Petitioner was again seen by Dr. Komanduri on December 29, 2003. The medical record indicated that Mr. Knezevich had been involved in an automobile accident. Petitioner was doing well with his cervical strain and had no pain or discomfort. He had regained about 80 percent of his function and mobility. He was released to full activity and discharged from Dr. Komanduri's care. Dr. Komanduri stated that any remnant from the auto accident had essentially been resolved. PX.14.

Petitioner testified that he hurt his back 3 times prior to 2006: in 1997 or 1998, in 1991, and in the late 80s. T.20. It was not a chronic issue, however. *Id.* He was not having any back issue between 2003 and 2006. T.54.

Petitioner began working for Martin Cement in June 2006 and previously worked for the them 1 time on April 17, 2006. He would work 5 days a week, 8 hours a day with mandatory overtime. T.14. His regular work week would have been 40 hours unless overtime was required. T.15.

By the pay stub for the week ending April 23, 2006, Mr. Knezevich worked 8 hours on April 17, 2006. His earnings were $245.20. PX.18. For the week ending June 18, 2006, he worked 16.50 hours over 2 days and earned $528.00. He sustained the left thumb injury on June 14, 2006. For the week ending August 6, 2006, Petitioner worked 12.50 hours over 2 days and earned $400.00. For the week ending August 13, 2006, he worked 59 hours over 6 days and earned $1,923.40. He had overtime earnings of $898.60 for the above weeks worked. PX.19.

Petitioner sustained an injury to his left thumb on June 14, 2006. T.23. Petitioner returned to work on August 4, 2006 with a 15 to 20 pound lifting restriction and he was advised to wear a splint. PX.1.

Mr. Randall Starck has been employed by the respondent for 45 years. He stated that overtime was not mandatory. T.51. He had a conversation with Mr. Knezevich on August 4, 2006 about his return to work following his thumb injury in July 2006. T.55. He offered Petitioner a job within his restriction and Petitioner stated he didn't feel he could go back to work. *Id.* Petitioner told him that he knows how this works. He said "you have me go back to work and they give me a smaller settlement." T.56. Petitioner testified that he never mentioned a settlement to Mr. Starck.

On August 14, 2006, Petitioner's back went out as he attempted to lift rebar. T.27. He allegedly felt a snapping sensation in his lower back and had pain in his legs. *Id.* The rebar he alleged weighed approximately 15 pounds. He reported the accident that day and went to Adventist the following day. T.27.

Petitioner presented to Adventist Hospital on August 15, 2006 alleging constant, sharp to moderate low back pain. He had normal strength and his lumbar spine was tender. He was diagnosed with a back strain. PX.12.

Petitioner began physical therapy at Provena Saint Joseph Medical Center on August 23, 2006. His pain was 4 to 5 out of 10 which was described as achy. He alleged his pain radiated into his bilateral posterior thighs. During the September 6, 2006 session, he was 10% better, but had a minimal decrease in his pain with daily living. His objective findings remained the same. PX.1.

Mr. Knezevich underwent an MRI of the lumbar spine at Joliet Open MRI on August 26, 2006. The MRI revealed degenerative bulging with tiny annulus fibrosis tears at L3-L4 and L4-L5. There was a tiny left sided disc herniation superimposed on degenerative bulging at L5-S1. There was no evidence of definite nerve compression at L5-S1. PX.1.

Petitioner was seen by Dr. Michael Cohen on September 21, 2006 for his thumb injury. According to Dr. Cohen's medical report, Petitioner became enraged and started yelling at him

and putting his index finger within inches of his (Cohen) face. Dr. Cohen told Petitioner to find a new physician; Petitioner asked to see Dr. Bednar. Dr. Cohen stated this seemed pre-planned. Dr. Cohen stated the anger seemed to be based on the fact that Petitioner was blaming him for his back injury when he returned to light duty. Petitioner felt he should have been off work for the thumb injury until he was 100 percent. Dr. Cohen noted this did not make sense. He stated Petitioner indicated that he could not prove that it was related but knew that it was. PX.1.

Petitioner stated that he was angry that he was released to light duty work and messed up his back. T.30. If the doctor would have waited one more month he would still be working today. *Id.*

Petitioner underwent physical therapy on September 25, 2006. His pain was 3/10 and achy. He had no complaints of bilateral lower extremity pain. He had occasional shooting pain in the bilateral lower extremities. He was 10 to 15 percent improved. He had an increase in his lumbar active range of motion. He was able to forward bend to 6 inches above the floor, which elicited pain in the mid lumbar spine. He could side bend to the popliteal crease. Backward bending, rotation right and rotation left were pain free and within normal limits. PX.1.

Petitioner was discharged from physical therapy on October 25, 2006. He had a 3 out of 10 pain that was achy in the mid lumbar spine. He had occasional sharp pain in the lumbar spine. He had numbness and tingling in the left first through third toes as well as the right first through second toe. He reported feeling 20 to 25 percent better. He could forward bend to 9 inches above the floor with pain in the left lumbar spine, left gluteals, posterior left thigh and posterior left knee. Backward bending and rotation to right were 25 percent limited and elicited pain in the left lumbar region. Despite his improvement, he continued to experience significant functional limitations throughout daily activities secondary to lumbar symptoms and bilateral lower extremity pain. The diagnosis was degenerative joint disease. PX.1.

On October 30, 2006, Dr. Komanduri discussed epidural injections with Petitioner. There would be 3 injections over 6 to 8 weeks with MMI anticipated within the next 3 months. Dr. Komanduri had nothing else to offer expect continued rehabilitation. PX.1.

On November 29, 2006, Dr. Komanduri noted the first injection provided 3 days of relief. Dr. Komanduri stated the disc did not require surgical intervention. His symptoms were primarily low back and would be better served with a home exercise program and anti-inflammatory medication. PX.1.

Petitioner underwent physical therapy on December 28, 2006. His pain was 3 out of 10 in the lumbar spine. Petitioner reported that he had an exacerbation of his symptoms over the weekend causing his pain to be 6 out of 10. Since the second injection, his symptoms of pain, numbness, and tingling were worse. Objectively he had improvement with lumbar spine active range of motion, muscular irritation, and bilateral hamstring flexibility. PX.1.

On January 3, 2007, Dr. Komanduri recommended the final injection, but Petitioner continued to make limited progress. There was little else he could do for Petitioner and he did not have the pain scales to warrant surgical management. If his pain did not improve then he

would recommend work conditioning and an FCE. A Section 12 examination would be recommended if he was unwilling to comply. PX.1.

Respondent obtained a Section 12 examination and opinion from Dr. Edward Goldberg on January 22, 2007. He reviewed the actual August 26, 2006 MRI and noted there was slight disc degeneration at L3-S1. There were small annular tears at L3-L5. There were no herniations. There was disc degeneration at L5-S1. Petitioner did not have any positive Waddell signs. Prognosis for recovery was good. His degenerative disc disease predated the accident, but could have been aggravated by the accident. He was not a surgical candidate but should undergo work hardening. He could work with a 10 pound restriction. PX.17.

Petitioner was seen by Dr. Komanduri on January 29, 2007. He had minimal improvement from the therapy and injections. He recommended Petitioner see Dr. Hersonskey, a neurosurgeon. He had nothing else to offer and no intent of seeing him back. He was continued off work. PX.1.

Dr. Komanduri was subsequently deposed on May 24, 2012. He opined that Petitioner had a pre-existing degenerative back disease and his back condition was causally related to the accident. PX.14. pg.20. His permanent restrictions were the result of the accident. PX.14. pg.21. However, on cross-examination, Komanduri testified that he was not aware that Petitioner entered into a divorce decree indicating he was totally disabled and tragically incapable of paying child support. PX.14. pg.26. He was not aware that Petitioner had been declared totally disabled going to all the way back to 1990. *Id.*

Dr. Komanduri was asked to explain how a person can go from being totally disabled to being capable of working full duty. PX.14. pg.27. Dr. Komanduri testified that "Obviously, he wasn't disabled." *Id.* He testified that Petitioner also had permanent restrictions regarding the shoulder in 2002. Petitioner then entered into a lump sum settlement indicating he was incapable of returning to work as an Iron Worker. PX.14. pg.30. Dr. Komanduri testified that he would be very uncomfortable if a person indicated a loss of trade more than one time. PX.14. pg.32. He stated that it would be inappropriate for a person to go back to the exact same trade that they previously claimed they were incapacitated from. PX.14. pg.33. He was not aware that the Iron Workers' union had a trial return to work program for someone coming off of disability.

Petitioner was seen by Dr. Hersonskey of the University of Illinois at Chicago on February 13, 2007. Petitioner's motor strength was not impaired. He had major sensitivity to pressure over his sacroiliac joint bilaterally that resembled his low back pain. The straight leg raising test created pain over the buttock bilaterally. The MRI did not reveal any major compression of the neural element. At L5-S1 there was a small disk herniation which could be putting pressure on both nerve roots and explain his symptoms. Dr. Hersonskey recommended a trigger point injection at the sacroiliac joint along with an updated MRI. Petitioner could work light duty with no heavy lifting over 15 pounds, no excessive bending or twisting for one month. PX.2.

Petitioner underwent an EMG on March 5, 2007 at Provena Saint Joseph for back pain that radiated down both legs. He had numbness in his toes with difficulty walking. The study was

normal. There was no electro-diagnostic evidence of a right or left peroneal neuropathy, no evidence of a right or left tibial neuropathy or surreal neuropathy, and no evidence of a right or left radiculopathy or myopathy. PX.13.

Petitioner underwent a lumbar MRI at Provena on March 6, 2007. There was a small relatively broad based disk protrusion centrally and to the left side with small associated osteophyte formation causing minimal anterior impression on the thecal sac at L5-S1. There was mild bilateral foraminal narrowing at L5-S1 with mild facet hypertrophy without displacement of the L5 nerve root. PX.1.

Petitioner had a follow-up examination with Dr. Hersonskey on April 10, 2007. Dr. Hersonskey found the examination consistent with sensitivity to pressure over the left buttock and over the left sacroiliac joint. His strength was otherwise normal. The L5-S1 interspace on the left side was slightly narrower, which could explain some left L5-S1 radiculopathy. He was taken off work. PX.2.

On April 25, 2007, Dr. Goldberg reiterated his opinions from his prior Section 12 examination. PX.17.

Petitioner saw Dr. Hersonskey on November 9, 2007. Dr. Hersonskey stated Petitioner had not yet exhausted physical therapy. He had very mild foraminal stenosis on the left side, which could potentially explain his symptoms. He recommended an MRI. PX.2.

Petitioner resumed physical therapy on November 21, 2007. On December 11, 2007, Petitioner could not tolerate even gentle extension exercises which might help his bulging disc, but appeared to significantly aggravate the spondylosis. They were discontinued. On February 26, 2008, Petitioner refused several of the stretches (i.e. piriformis and faber) as he believed it was causing more pain than he had without the stretches. PX.1.

On March 31, 2008, Dr. Goldberg reiterated his opinions from his prior Section 12 examination.

Petitioner underwent an MRI of the lumbar spine on November 14, 2008 at Future Diagnostic Group. The MRI revealed mild degenerative disc disease in the lower lumbar spine. There were no critical areas of central canal narrowing or neural foraminal stenosis. At L3-L4, L4-L5 there was a tiny diffuse disc bulge that flattened the anterior thecal sac but did not cause any significant central canal narrowing or neural foraminal stenosis. At L5-S1 there was a tiny posterior central disc protrusion which flattened the anterior thecal sac and did not cause any significant central canal narrowing. PX.4.

The MRI of the cervical spine performed that day revealed degenerative disc disease at several levels but most pronounced at C6-C7. There were no significant areas of central canal stenosis. There were varying degrees of neural foraminal narrowing at several levels with mild to severe stenosis. PX.4.

Petitioner underwent an EMG on December 10, 2008. The EMG revealed evidence for

moderate sensorimotor, demylinating type, neuropathy in the lower extremities. There was no evidence of chronic/active denervation noted. PX.1.

Petitioner was seen by Dr. Lichtenbaum of the University of Illinois at Chicago on January 23, 2009. He reviewed the MRI of the cervical and lumbar spine and noted that it did not reveal any neurosurgical pathology. There was no evidence of any compression at any place and no neurosurgical pathology. Surgery was not recommended. Petitioner had 5/5 strength throughout the upper and lower extremity including the deltoids, biceps, triceps, hand intrinsic, grip, iliosoas, quadriceps, dorsiflexion, EHL and plantar flexion. PX.1.

Petitioner underwent an FCE on January 30, 2009 that revealed a full physical effort. Petitioner's job of ironworker did not provide for light duty and he did not meet the demands of his position as an ironworker. His maximum one time lift was 60 pounds and his frequent lift capacity was 50 pounds. He was unable to sustain climbing of ladders and was unable to attempt push/pull test items due to low back and thumb pain. He could work in the medium demand level. PX.5.

On June 12, 2009, Dr. Goldberg reviewed the FCE noting it was valid. He could work within the parameters of the FCE. He was at MMI. PX.17.

Susan Entenberg performed a vocational evaluation on June 20, 2010 and was subsequently deposed April 7, 2011. She testified that Petitioner was not capable of performing his past work duties. He was an appropriate candidate for vocational rehabilitation in the form of job placement. He could expect to earn between $10.00 and $15.00 per hour. She then performed a second evaluation on October 30, 2010. She reviewed Petitioner's job search logs and concluded that he performed a diligent job search which yielded no jobs. She opined that a stable labor market did not exist. PX.16. Petitioner testified that he would currently earn $41.00 if he was still employed as an iron worker.

The Petitioner submitted his job search logs into evidence. The Commission thoroughly examined the logs. The logs reveal that he contacted numerous employers multiple times. The September 4, 2010 log reveals that he contacted Arbys, Baskin Robins, Cajun Café, Hot Dawg, Niro Japan, Panda Express, Sbarro, Subway, Taco Bell. Then in the Genex September 23, 2011 search logs, Petitioner applied for the same positions at the same locations except Niro Japan, Subway and Taco Bell. On September 5, 2010, petitioner applied for jobs at Fox Valley Watch, Lau Jewelry, Luxe 925. He then applied for the same jobs on September 23, 2011. The job search logs are replete with similar instances. Assuming he applied, Petitioner also applied for the same job multiple times. He applied at Sign O Rama on October 5, 2010 and February 21, 2011. Sulzer Pumps on October 5, 2011 and February 28, 2011. He contacted the same employers on September 22, 2010 and March 9, 2011; October 18, 2010 and March 15, 2011; and October 5, 2011 and February 28, 2011. There are also days where he applied for multiple jobs at the local mall. There are days when he applied at floral shops only, hotels only, or restaurants only. Petitioner indicated he found those jobs in the Yellow Book. PX.22.

Petitioner testified that he contacted 1181 employers and did not receive an interview or job offer. T.50. He stated that, of the almost 1200 employers he applied, only 280 were hiring. T.27.

Dr. Avi Bernstein was deposed on July 14, 2011. RX.9. He performed a Section 12 examination on January 27, 2011. He noted that the November 14, 2008 MRI revealed typical degenerative changes consistent with Petitioner's age. He had fairly good disc preservation throughout his low back. He had more degenerative involvement at L5-S1. There was a central protrusion but no disc herniation and no nerve root compression. It was a very typical scan for a 61 year old. RX.9. pg.10. Dr. Bernstein opined that Petitioner had a routine degenerative condition of the lumbar spine. *Id.* No further treatment was necessary. He could work within the parameters of the January 30, 2009 FCE. RX.9. pg.11. The limitations from the FCE were not work related. *Id.* He had multiple joint involvement in terms of another arthritic condition. Dr. Bernstein would restrict Petitioner from working as an iron worker based on all of his diffuse complaints, not just his back. RX.9. pg.12. Petitioner's restrictions were not related to his work accident. RX.9. pg.13. Dr. Bernstein could not relate any restrictions to the accident. On cross-examination, he agreed there was a causal relationship between the lower back injury and the August 14, 2006 injury. RX.9. pg.26.

On October 7, 2011, Dr. Goldberg reviewed the following documents: a statement from the Social Security Administration dated January 4, 1992 indicating Petitioner was totally disabled; the trial work program letter dated October 5, 1996 indicating Petitioner wished to return to his original position; the IWCC settlement indicating Petitioner injured his bilateral knees and shoulders; the November 8, 2000 FCE placing Petitioner at a light to medium level with occasional 35 pound lift and carry restrictions. Dr. Goldberg noted that he did not see any additional records indicating Petitioner was ever released to full duty. He did not believe Petitioner had any restrictions referable to the work-related accident of August 14, 2006 as he had greater restrictions prior to the accident. PX.17.

Dr. Goldberg was deposed on January 9, 2012. He opined that petitioner aggravated his pre-existing back condition and had a degenerative disc at L5-S1. He felt Petitioner could work with a 10 pound lifting restriction and he possibly needed work conditioning. PX.17. pg.7. He did not require surgery. He still found causal connection. Dr. Goldberg changed his opinion on October 7, 2011 after meeting with respondent's attorney. He reviewed the SSA report indicating Petitioner was previously declared totally disabled. He stated that the review of the FCE from November 2000 was the reason he changed his opinion. PX.17. pg.20. He then stated that because the Petitioner returned to work as an iron worker in 2003, his current condition was related to the 2006 accident.

Petitioner was seen by Dr. Ranjeet Singh of Health Benefits on February 9, 2012. Petitioner indicated that his pain was not as bothersome as it once was stating that it was minimal, and with Lidoderm ointment and Tylenol his pain was virtually non-existent. He had minimal to moderate tenderness at the paralumbosacral region. He had a negative seated root and straight leg raise. He had pain at 90 degrees with forward flexion and pain with extension at 10 degrees. The assessment was lumbar degenerative disc disease, lumbago and chronic pain syndrome due to trauma. Dr. Singh found Petitioner was at MMI and could continue to use his

TENS unit and his home exercise program twice daily to help deal with his overall co-morbidities. PX.3.

Petitioner's attorney obtained an opinion from Dr. Komanduri on May 2, 2012. The Petitioner had chronic degenerative disc disease that was aggravated by the work accident. He sustained some permanent loss as a result of the aggravation. His condition was not surgical. He was placed at permanent medium duty. PX.14.

Petitioner alleges that he still has low back pain and issues with his mobility. He performs therapy exercises every morning. He takes a lot of Ibuprofen and uses a TENS unit and Lidocaine patch. T.55. He is currently receives social security disability benefits.

The Commission is troubled by the record. The record is replete with evidence demonstrating actions inconsistent with the intent of the Act; actions the Commission views as disingenuous and an intentional effort by the Petitioner to mislead the doctors and vocational experts. The Petitioner submitted into evidence a job search that is nothing more than farcical. Because of the Petitioner's actions, the Commission finds Petitioner is not credible. The Commission finds that Petitioner reached MMI as of July 14, 2011, the date of Dr. Bernstein's evidence deposition.

The Commission is not bound by the Arbitrator's findings, and may properly determine the credibility of witnesses, weigh their testimony and assess the weight to be given to the evidence. *R.A. Cullinan & Sons v. Industrial Comm'n*, 216 Ill. App. 3d 1048, 1054, 575 N.E.2d 1240, 159 Ill. Dec. 180 (1991). It is the province of the Commission to weigh the evidence and draw reasonable inferences therefrom. *Niles Police Department v. Industrial Comm'n*, 83 Ill. 2d 528, 533-34, 416 N.E.2d 243, 245, 48 Ill. Dec. 212 (1981). Interpretation of medical testimony is particularly within the province of the Commission. *A. O. Smith Corp. v. Industrial Comm'n*, 51 Ill. 2d 533, 536-37, 283 N.E.2d 875, 877 (1972).

The Commission finds that the below evidence negatively impacts Petitioner's credibility:

First, the Petitioner sustained a prior work injury on October 21, 1999. Petitioner underwent a functional capacity examination (FCE) on November 8, 2000. The FCE revealed Petitioner could not return to work as an iron worker as he could only work in the light to medium duty demand level. He was advised to seek alternative employment. Petitioner was off work between 1999 and 2003.

Petitioner subsequently entered into a lump sum settlement contract, alleging complete disability under Section 8(f) of the Act on April 16, 2003. Pursuant to the settlement, Petitioner received $194,827.60, representing $508.72 per month for his remaining 28.5 years of life expectancy. Petitioner testified that the contract stated he was unable to return to work as an ironworker. However, within one to two months of settling his claim, the Petitioner returned to work as an iron worker. The Commission is not persuaded by Petitioner's testimony that he was able to return to work because of his extensive therapy and exercise.

Second, the Commission finds Mr. Starck's testimony insightful. Mr. Starck testified that Respondent offered Petitioner a job on August 4, 2006 that was within his restrictions following his July 2006 injury. T.55. Mr. Starck testified that Petitioner stated "I know how this works. You get me back to work, and then they give me a small settlement. It's not going to be like that." T.56.

Third, Dr. Cohen's September 21, 2006 medical record, contained in Petitioner's Exhibit 1, further impacts Petitioner's credibility. Dr. Cohen indicated Petitioner became enraged and started yelling at him. He asked to find a new physician. Dr. Cohen noted this seemed pre-planned. This is troubling to the Commission in light of the totality of the record.

Fourth, the Commission gives no weight to Dr. Komanduri's restrictions given the incomplete history provided to him by Petitioner. Dr. Komanduri testified that he was not aware that Petitioner was previously found to be incapable of working as an iron worker. He was not aware that Petitioner previously entered into a divorce decree indicating he was totally disabled and tragically incapable of paying child support. Dr. Komanduri testified that he would be very uncomfortable if a person indicated they lost their trade more than one time and that it would be inappropriate for a person to go back to the exact same trade they were previously incapacitated from. Based upon Petitioner's inaccurate history as provided to Dr. Komanduri, the Commission gives no weight to Dr. Komanduri's opinions regarding Petitioner's inability to return to work.

Fifth, the November 2000 FCE revealed Petitioner could work in the light to medium demand level only. The Commission notes, however, that this restriction is greater than the restrictions from the January 2009 FCE, which found Petitioner was capable of working at the medium demand level.

Sixth, despite Petitioner's more restrictive limitations as set forth in the FCE of 2000, he was able to undergo therapy and exercise and return to work. But, this was only after his settlement. He claimed he did not want to be a "dole" on society. T.37.

Based upon the above, the Commission adopts the opinions contained in Dr. Bernstein's July 14, 2011 evidence deposition. In so adopting his opinions, the Commission finds Petitioner reached MMI as of July 14, 2011, the date Dr. Bernstein opined Petitioner was capable of performing work consistent with the January 2009 FCE. Dr. Bernstein further found the November 2008 MRI very typical for a man of Petitioner's age. The central disc protrusion was not a herniation and he did not suffer from nerve root compression. He noted the FCE limitations from 2009 were not related to Petitioner's August 14, 2006 work accident.

The Petitioner now asks the Commission to find that he is incapable of working, despite having lesser restrictions. He asks the Commission to find that he performed a diligent job search by applying for over 1100 jobs, only to find no employment. The Petitioner requests that the Commission accept Susan Entenberg's opinion that he performed a diligent job search and that a stable labor market does not exist for him. The Commission declines.

The Commission performed an extensive review of the Petitioner's job search logs and is left questioning the sincerity of Petitioner's efforts and the integrity of Ms. Entenberg's opinions.

The Commission affords no weight to either.

The job search logs represent Petitioner's alleged self-directed job search and the job search performed with Genex. The Petitioner testified that he applied for almost 1200 jobs. The Commission notes that the logs do, in fact, contain numerous jobs for which he allegedly applied. The Commission notes, however, that on various days he applied for the same jobs and in the same order as he did on previous days.

Petitioner also contacted various employers by simply opening the Yellow Pages and randomly calling businesses. He also contacted the same employer on multiple occasions several months apart. The Petitioner offered no evidence whether the employers were hiring or whether the jobs he applied for were within his restriction. The Commission is not persuaded by Petitioner's job search and is baffled by Ms. Entenberg's illusory conclusion that Petitioner performed a diligent job search.

An employee need not be reduced to complete physical incapacity to be entitled to PTD benefits. *Ceco Corp. v. Industrial Comm'n*, 95 Ill. 2d 278, 286, 447 N.E.2d 842, 845, 69 Ill. Dec. 407 (1983). Instead, a PTD award is proper when the employee can make no contribution to industry sufficient to earn a wage. *Westin Hotel v. Industrial Comm'n*, 372 Ill. App. 3d 527, 544, 865 N.E.2d 342, 357, 310 Ill. Dec. 18 (2007). "The focus of the Commission's analysis must be upon the degree to which the claimant's medical disability impairs his employability." *Alano v. Industrial Comm'n*, 282 Ill. App. 3d 531, 534, 668 N.E.2d 21, 24, 217 Ill. Dec. 836 (1996). A person is not entitled to PTD benefits if he is qualified for and capable of obtaining gainful employment without seriously endangering his health or life. *Interlake, Inc. v. Industrial Comm'n*, 86 Ill. 2d 168, 176, 427 N.E.2d 103, 107, 56 Ill. Dec. 23 (1981).

The odd-lot category for purposes of a PTD award arises when a "claimant's disability is limited in nature so that he is not obviously unemployable, or if there is no medical evidence to support a claim of total disability." *Valley Mould & Iron Co. v. Industrial Commission*, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159, 1163, 50 Ill. Dec. 710 (1981). In these situations, the claimant can establish that he is entitled to PTD benefits under the "odd-lot" category by proving the unavailability of employment to persons in his circumstances. *Ameritech Services, Inc. v. Illinois Workers' Compensation Comm'n*, 389 Ill. App. 3d 191, 204, 904 N.E.2d 1122, 1133, 328 Ill. Dec. 612 (2009).

The claimant ordinarily satisfies his burden of proving that he falls into the odd-lot category in one of two ways: (1) by showing diligent but unsuccessful attempts to find work, or (2) by showing that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market." *Westin Hotel*, 372 Ill. App. 3d at 544, 865 N.E.2d at 357. If the claimant establishes that he fits into the odd-lot category, the burden shifts to the employer to prove that the claimant is employable in a stable labor market and that such a market exists. *Id.*

The Commission finds Petitioner is not entitled to permanent total disability benefits as he is qualified for and capable of obtaining gainful employment without seriously endangering his health or life. The Commission notes that Petitioner's complaints were largely subjective

15IWCC0626

with little evidence of any significant objective findings. Because the Commission has great doubt regarding the sincerity of Petitioner's efforts, such subjective statements are afforded no weight.

The Commission notes that during the December 28, 2006 physical therapy session, Petitioner had objectively improved. Further, the March 5, 2007 EMG was normal; multiple doctors noted Petitioner was not a surgical candidate; he had 5/5 strength through the upper and lower extremities; and, there was no nerve root compression. Furthermore, during Dr. Singh's February 9, 2012 examination revealed Petitioner's pain was virtually negative.

Assuming Petitioner qualified under the odd-lot theory of disability, the Commission, for the reasons stated above, finds that he failed to establish a diligent but unsuccessful job search or that because of his age, skills, training, and work history, he will not be regularly employed in a well-known branch of the labor market.

The Commission, therefore, finds Petitioner is entitled to TTD from August 14, 2006 through July 14, 2011, representing 256-4/7 weeks. The Commission awards Petitioner all reasonable and necessary medical expenses through July 14, 2011.

The Commission finds Petitioner is entitled to 25% loss of use of the man-as-a-whole pursuant to Section 8(d)(2). The Petitioner's argument centers upon an alleged loss of trade, in that he can no longer work as an iron worker. He has apparently made similar allegations in the past. Yet he has consistently returned to iron work when his litigation has ended.

For obvious reasons, the Commission has great difficulty with Petitioner's credibility, and its doubt is so great that the Commission finds that the Petitioner is neither entitled to a PTD nor a wage differential award. Had the Commission given credence to Petitioner's loss of trade argument, then a higher value may have been awarded.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 14, 2014, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,032.20 per week for a period of 256-4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $619.97 per week for a period of 125 weeks, as provided in §8(d)(2) of the Act, for the reason that the injuries sustained caused 25% loss of use of the man-as-a-whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner all reasonable and necessary medical expenses through July 14, 2011 under §8(a) of the Act and subject to the medical fee schedule.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

15IWCC0626

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

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

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

DATED: AUG 13 2015

Michael J. Brennan

MJB/tdm
O: 7-14-15
052

Thomas J. Tyrrell

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KNEZEVICH, RON
Employee/Petitioner

Case# **06WC047052**
06WC047051

MARTIN CEMENT CO INC
Employer/Respondent

15IWCC0626

On 10/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0274 HORWITZ HORWITZ & ASSOC LTD
MITCHELL W HORWITZ
25 E WASHINGTON ST SUITE 900
CHICAGO, IL 60602

2986 PAUL A COGHLAN & ASSOC PC
15 SPINNING WHEEL RD
SUITE 100
HINSDALE, IL 60521

STATE OF ILLINOIS)
)SS.
COUNTY OF Will)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Ron Knezevich
Employee/Petitioner

v.

Martin Cement Co., Inc.
Employer/Respondent

Case # **06** WC **47052**

Consolidated cases: **06 WC 47051**

15IWCC0626

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 **George Andros**, Arbitrator of the Commission, in the city of **New Lenox and Chicago**, on **July 17, 2013 and July 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 14, 2006**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**83,431.92**; the average weekly wage was $**1,548.30**.

On the date of accident, Petitioner was **56** years of age, ***single*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**174.895.54** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**174,895.54**.

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 $1,032.20/week for 130.42 weeks, commencing August 15, 2006 through February 12, 2009, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner maintenance benefits of $1,032.20/week for 112 weeks, commencing February 13, 2009 through April 7, 2011, as provided in Section 8(a) of the Act.

Respondent shall pay reasonable and necessary medical services of $17,497.25, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent and total disability benefits of $1,032.20/week for life, commencing April 8, 2011, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the ***Rate Adjustment Fund***, as provided in Section 8(g) of the Act.

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.

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

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

#01 George J. Andros

#01 Arbitrator George Andros

October 09, 2014
Date

OCT 14 2014

FINDINGS OF FACT

The petitioner, Ron Knezevich testified that from 1968 through 1972, he served in the United States Marine Corps, with service in Vietnam. (Tr. 7/17/13 @ 7). After serving in the Marines, the petitioner began working as an iron worker out of Local 444. (Tr. 7/17/13 @ 8).

As an iron worker, the petitioner lifted up to 100 pounds, placing rebar, mesh and rigging. The petitioner would also have to climb on the job and wore a tool belt weighing from 20 to 45 pounds. (Tr. 7/17/13 @ 9). During the years of 2003 through 2006, the petitioner worked in a full duty capacity as an iron worker. (Tr. 7/17/13 @ 9-10). From 2003 to 2006, the petitioner worked 2,985 hours as an ironworker, per the documentation of Mid America Funds. (Tr. 7/17/13 @ 10). There were no physical restrictions imposed on the petitioner during that period. (Tr. 7/17/13 @ 10-11).

The petitioner began working for the respondent, Martin Cement, in June of 2006. The petitioner sustained an injury while working for Martin Cement on June 14, 2006, two days after beginning his work there. (Tr. 7/17/13 @ 11).

When the petitioner began work for the respondent, he explained that a normal work week was 5 days, with 8 hours per day. Overtime was required since the petitioner was a union steward and the local he worked from required an ironworker to be on the job while concrete was being poured. If he left during that time, he could be written up by his own local. (Tr. 7/17/13 @ 14).

On June 14, 2006, the petitioner testified that he was setting rebar for the respondent. This work involved lifting the rebar into place, which could weigh anywhere from 30 to 100 pounds. (Tr. 7/17/13 @ 21-22). The petitioner explained that he needed to cut a brick in half with his pliers, but stumbled and smashed his left thumb against the brick with his pliers. (Tr. 7/17/13 @ 22-23). On that same date, the petitioner was seen at Provena St. Joseph medical Center, where he was treated for a left thumb injury. The petitioner was diagnosed with a left thumb comminuted distal phalanx facture and a full thickness laceration of the nail bed. He was placed on an off work restriction and advised to follow up with an orthopedic surgeon. (PX 13).

On June 19, 2014, the petitioner was seen by Dr. Michael Cohen at Will County Medical Associates. Dr. Cohen diagnosed the petitioner with a comminuted mildly displaced tuft fracture of the distal phalanx of the left thumb. Dr. Cohen placed the petitioner in a left thumb splint and restricted the petitioner to no work with the left hand. (PX 9).

The petitioner continued to follow up with Dr. Cohen through July of 2006. On July 27, 2006, Dr. Cohen noted that the petitioner still had decreased sensation in the tip of his left thumb and x-rays showed some visible fracture lines still present in the tuft of the thumb. Dr. Cohen released the petitioner to work with a 15-20 pound lifting restriction on the left upper extremity, with no climbing and with the need to wear his thumb splint. (PX 9).

On August 4, 2006, the petitioner returned to work within the restrictions imposed by Dr. Cohen. (Tr. 7/17/13 @ 24). The petitioner returned to work for the respondent, again setting and placing rebar, which he attempted to do with a splint on his left hand. (Tr. 7/17/13 @ 25-26).

After the first injury, the petitioner returned to work for the respondent on August 4, 2006 and worked five 10 hours days and an 8 hour day prior to being injured again on August 14, 2006. (Tr. 7/17/13 @ 15). The petitioner was on light duty during this time. (Tr. 7/17/13 @ 16).

The petitioner testified as to the hours he worked in August 2006 for the respondent, explaining that any work above 8 hours in a day and work on Saturdays was overtime, which was mandatory. (Tr. 7/17/13 @ 18-19). All overtime was paid at double time. (Tr. 7/17/13 @ 20). If the petitioner refused to do the overtime work, he testified that they would get someone else to do the work and he could be brought up on charges from his local. (Tr. 7/17/13 @ 20-21).

On August 14, 2006, the petitioner testified that he was going to get some dowels, which were approximately 3 foot long pieces of rebar laying in a pile and partially covered with gravel. (Tr. 7/17/13 @ 26). Around the bundle of dowels was a No. 9 wire. (Tr. 7/17/13 @ 26). When the petitioner used his right hand to try to grab a bundle of rebar, he found the bundle was stuck. He attempted to pull the bundle of rebar again and felt a snapping sensation in his lower back with pain into his legs. (Tr. 7/17/13 @ 26-27). On August 15, 2006, the petitioner was seen at Adventist Midwest Health. There it was noted that the petitioner was injured the day prior while lifting rebar at work. The petitioner injured his lower back and was complaining of tingling in the first and second toes of the right foot. The petitioner was given pain medication and placed on an off work status. (PX 12). On August 21, 2006, the petitioner was seen by Dr. Mukund Komanduri. He reported to Dr. Komanduri that he had bent over to pick up three bars of iron, weighing about 15 pounds total, and while trying to get them off the ground felt a severe pain in his lower back. Dr. Komanduri kept the petitioner off work and recommended physical therapy, anti-inflammatory medication, and a MRI of the lumbar spine. (PX 1).

The petitioner began physical therapy at Provena St. Joseph Medical Center on August 23, 2006. (PX 13). On August 24, 2006, the petitioner followed up with Dr. Cohen, who noted that the petitioner continued to have a fracture line visible on x-rays which he opined may have been a fibrous union. Dr. Cohen further noted that the petitioner continued to have stiffness in his thumb and recommended that the petitioner begin a course of hand therapy. The petitioner was cleared to return to work, from his left hand injury only, with use of his splint as needed. (PX 9).

On August 26, 2006, the petitioner underwent a lumbar MRI at Joliet Open MRI. The MRI revealed 1) degenerative bulging with tiny annulus fibrosis at L3-4 and L4-5 and 2) tiny left sided disc herniation superimposed on degenerative bulging at L5-S1. (PX 1).

On August 28, 2006, the petitioner began hand therapy at Provena St. Joseph Medical Center. The petitioner underwent hand therapy on August 28, 2006 and September 2, 2006. The petitioner was then instructed on home range of motion and strengthening exercises for his thumb. (PX 13). On September 6, 2006, the petitioner followed up with Dr. Komanduri who reviewed the petitioner's MRI which confirmed a L5-S1 disc herniation. Dr. Komanduri recommended epidural steroid injections and kept the petitioner off work. (PX 1).

On September 21, 2006, the petitioner followed up with Dr. Cohen who opined that the petitioner may have had some early stenosing tenosynovitis in the left thumb and recommended a cortisone injection and possibly some additional physical therapy. At that time, the petitioner became agitated and Dr. Cohen recommended he see another physician. He placed the petitioner on a 10 to 15 pound lifting restriction for the left hand and recommended that the petitioner follow the restrictions placed on him by Dr. Komanduri, who had taken the petitioner completely off work due to his back injury. (PX 9). (emphasis added)

On September 25, 2006, the petitioner was seen by Dr. Jerry Chow at Provena St. Joseph Medical Center. Dr. Chow diagnosed stenosing tenosynovitis of the left thumb and recommended either a cortisone shot for temporary relief or surgery for permanent relief. The petitioner was placed on an off work status at that time. (PX 7).

The petitioner returned to Dr. Komanduri on September 27, 2006. At that time, Dr. Komanduri noted the petitioner's continued lower back pain and again recommended epidural injections and continued physical therapy. The petitioner remained off work. (PX 1). On November 21, 2006, the petitioner underwent an epidural steroid injection, which was performed by Dr. James Wilson upon a referral by Dr. Komanduri. Dr. Wilson diagnosed degenerative disk bulging at L3-4 and L4-5 and tiny left-sided disk herniation at L5-S1 with bilateral lumbar radiculopathy. (PX 6).

On November 27, 2006, the petitioner saw Dr. Komanduri who noted that the petitioner got about 3 days of relief from the first epidural injection. Dr. Komanduri recommended additional physical therapy and continuation of the series of epidural injections. Dr. Komanduri noted that he did not feel the petitioner's condition would need surgical management. (PX 1).

On December 12, 2006, the petitioner was seen for a consultation on his left thumb by Dr. Thomas Wiedrich. Dr. Wiedrich diagnosed the petitioner with left thumb trigger thumb and recommended a cortisone injection into the left thumb. He limited the petitioner to a 2 pound lifting restriction with his left hand. Dr. Wiedrich noted that, if the cortisone injection was not successful, the petitioner would require a trigger thumb release surgery. (PX 7).

The petitioner underwent a second epidural injection from Dr. Wilson on December 19, 2006. (PX 13). The petitioner followed up with Dr. Komanduri on December 29, 2006 who noted that the petitioner continued to make limited progress in therapy and opined that he would benefit from one final epidural injection and work conditioning. The petitioner was kept off work at that time. (PX 1). On January 15, 2007, the petitioner underwent a left thumb cortisone injection, performed by Dr. Chow.

On January 22, 2007, the petitioner was seen for a Section 12 examination by Dr. Edward Goldberg at RUSH, at the request of the respondent. Dr. Goldberg diagnosed an aggravation of pre-existing degenerative disc disease of the lumbar spine which was caused by the petitioner's August 14, 2006 work accident. He further opined that the treatment to date had been appropriate. He recommended work hardening for four to six weeks. Dr. Goldberg felt that the petitioner could work with a 10 pound lifting restriction. (PX 17).

The petitioner followed up with Dr. Komanduri on January 29, 2007 who referred the petitioner for a neurosurgical consultation with Dr. Tamir Hersonskey from the University of Illinois at Chicago On February 13, 2007 Dr. Hersonskey diagnosed neuropathy and disc herniation and recommended a trigger point injection to the sacroiliac joint and a new lumbar MRI, as well as a lower extremity EMG. He underwent an upper extremity EMG on February 15 and a lower extremity EMG on March 5 plus updated MRI of the lumbar spine on March 6, 2007. (PX 13).

On March 12, 2007, Dr. Chow had the opportunity to review the petitioner's upper extremity EMG and diagnosed bilateral carpal tunnel syndrome with the left worse than the right. Dr. Chow continued to recommend a left thumb trigger thumb release and also now recommended carpal tunnel release surgery.

On April 10, 2007 Dr. Hersonskey recommended additional L5-S1 and sacroiliac joint injections and kept the petitioner off work. Petitioner continued to have a shooting pain around his lower back with radiation on the left side. (PX 2).

On April 18, 2007 Dr. Thomas Wiedrich performed a review of records via respondent. Dr. Wiedrich opined that the petitioner suffered from a left thumb trigger finger which was directly related to his June 14, 2006 work accident. The petitioner also had bilateral mild carpal tunnel syndrome, which Dr. Wiedrich did not feel was related to his work injury. Dr. Wiedrich recommended a left thumb trigger finger release and noted that Dr. Chow's treatment to date had been reasonable and necessary for the trigger thumb. (RX 10).

On May 22, 2007, Dr. Chow opined that the petitioner's left trigger thumb, left carpal tunnel syndrome and the fungus infection of the nail of the left thumb was causally related to his June 14, 2006 work accident. (PX 7). On June 4, 2007, the petitioner underwent a left sacroiliac joint arthrogram and injection performed by Dr. Satvinder Dhesi at Health Benefits Pain Management. (PX 3). On July 10, 2007, Dr. Chow reviewed the report from Dr. Wiedrich and drafted a narrative report in which he reiterated that the petitioner's carpal tunnel syndrome, trigger thumb and nail infection were all causally related to his June 14, 2006 work accident.

On August 27, 2007, the petitioner again saw Dr. Hersonskey who recommended additional physical therapy and kept the petitioner off work due to continued lower back and radiating pain. (PX 2). The petitioner then underwent a course of physical therapy from November 21, 2007 through February 26, 2008. (PX 1).

On February 26, 2008 Dr. Komanduri noted that the petitioner continued to have episodes of back pain when he was active. Dr. Komanduri recommended that the petitioner continue his course of therapy until he next saw Dr. Hersonskey two days after this appointment. (PX 1).

On February 28, 2008 Dr. Hersonskey ordered updated lumbar and cervical MRIs, an updated lower extremity EMG and cleared the petitioner to work with a 10 pound lifting restriction and no bending or twisting at the waist. (PX 2).

On March 31, 2008, the petitioner was seen again by Dr. Edward Goldberg. Dr. Goldberg reiterated that he felt the petitioner's lumbar condition was caused by an aggravation of his degenerative disc disease in the lumbar spine. He recommended a FCE to determine restrictions and cleared the petitioner to work with a 20 pound lifting restriction.

On May 22, 2008, the petitioner was seen by Dr. Leah Urbanosky for the left hand who recommended carpal tunnel release, flexor pollicis longus release, tenosynovectomy, and excision of the nail on the left thumb with debridement for the fungal infection. (PX 8). The petitioner followed up again with Dr. Urbanosky on June 13, 2008, who made the same recommendations and noted that the petitioner could not return to work. (PX 8).

On August 14, 2008, the petitioner underwent a surgery consisting of left carpal tunnel release, left trigger thumb release, exploration of the left ulnar digital nerve to the thumb by Dr. Urbanosky (PX 8). The petitioner followed up with Dr. Urbanosky on August 28, 2008, who recommended he begin physical therapy, post surgery. (PX 8).

The petitioner began physical therapy on September 3, 2008 at Hand Therapy Therapists, PC. (PX 11). The petitioner continued to undergo hand therapy and follow up with Dr. Urbanosky through December 17, 2008. During that time, Dr. Urbanosky kept the petitioner on a no work with the effected extremity restriction. (PX 8, 11). On December 18, 2008, the petitioner followed up with Dr. Urbanosky who noted a slight increase in the petitioner's overall grip strength, but that the petitioner still had tenderness in the thumb. Dr. Urbanosky recommended that the petitioner undergo a FCE and stated that he could return to work with no grasping with the thumb. (PX 8).

On January 30, 2009, the petitioner underwent a FCE. The findings of the examination were deemed valid and indicated that the petitioner could work only at a medium duty level. This included the ability to list 50 pounds frequently and 60 pounds one time. The petitioner was also unable to climb ladders and unable to complete the push/pull testing due to thumb pain. The therapist concluded, "Patient is not recommended to return to work as an ironworker at this time due to inability to meet the critical job demands of this position secondary to thumb and low back pain." (PX 5).

Upon being released by Dr. Urbanosky on February 12, 2009, it was the petitioner's impression that he had permanent physical restrictions of no lifting over 50 pounds occasionally with no ladder climbing. (Tr. 7/17/13 @ 38-40). Dr. Urbanosky's note from February 12, 2009 does release the petitioner within the restrictions imposed by the FCE, as permanent restrictions, and recommends job retraining for a supervisorial position. (PX 8).

On June 10, 2009, the petitioner was seen for a Section 12 examination by Dr. Wiedrich at the request of the respondent. Dr. Wiedrich concluded that the petitioner had no objective findings to substantiate his subjective complaints in the left thumb. However, Dr. Wiedrich admitted that the FCE was valid and should be construed as the petitioner's maximum capability.

On June 12, 2009, Dr. Goldberg again performed a Section 12 examination of the petitioner. Again, after reviewing additional records and examining the petitioner, Dr. Goldberg opined that the petitioner aggravated his degenerative disc disease from his work accident. He further opined that the petitioner could return to work within the restrictions outlined by the January 30, 2009 FCE.

At the first hearing in Will County petitioner testified as to the current condition of his left thumb. Currently, the petitioner notices that he could not apply pressure with it because it would become painful. (Tr. 7/17/13 @ 40). Regarding his lower back, the petitioner testified that he has to be very careful with sudden, jerky, twisty movements and be cognizant of bending his knees due to experiencing pain a lot of the time. The petitioner uses a TENS unit, a lot of Advil, Lidocaine patches, ice and heat. (Tr. 7/17/13 @ 40-41).

In 2009, after being released from care, the petitioner testified that he was still having pain in his hand and problems with his back. (Tr. 7/17/13 @ 41).

The petitioner testified that he received workers' compensation benefits up until the time he saw Dr. Avi Bernstein for a section 12 exam at behest of Respondent on January 27, 2011. (Tr. 7/17/13 @ 42-43).

After being released by Dr. Urbanosky, the petitioner began looking for work. He looked for various jobs with jewelry stores, places at the mall, through the Yellow Pages, call dealerships and others. (Tr. 7/17/13 @ 45). The petitioner looked for jobs within his restrictions in 2009 and did not find one. (Tr. 7/17/13 @ 46). The petitioner explained that there is no light duty in his trade, other than signaling positions which are few and far between. (Tr. 7/17/13 @ 46).

The petitioner kept a log of his job searches beginning in June of 2010. (Tr. 7/17/13 @ 47; PX 22). The petitioner explained a few of the jobs that he searches for, as contained in his logs. (Tr. 7/17/13 @ 47-49). From June 21, 2010 through October 15, 2011, the petitioner looked for work with 1,181 employers. (Tr. 7/17/13 @ 49). The petitioner received no job offers and no interviews during that time. (Tr. 7/17/13 @ 49-50).

The petitioner met with a vocational counselor from Genex Vocational Rehab Service tendered by Respondent's claim adjuster one time on August 5, 2010, but no further meetings were requested and no vocational support services or job direction was offered after that date. (Tr. 7/17/13 @ 50). The petitioner's job search was wholly self-directed. (Tr. 7/17/13 @ 51).

Had the petitioner not been injured in August of 2006, he planned on continuing with iron working. (Tr. 7/17/13 @ 52-53). If the petitioner was currently employed in the full performance of his duties as an ironworker with Local 444, he would have been earning $41 per hour at the time of hearing (Tr. 7/17/13 @ 53).

The respondent never offered the petitioner any light duty work after his August 2010 release from medical care. (Tr. 7/17/13 @ 53). The petitioner has sustained no new injuries to his lower back since August 14, 2006. (Tr. 7/17/13 @ 53-54). While working as an ironworker from 2003 to 2006, the petitioner had no problems at all with his lower back. (Tr. 7/17/13 @ 54).

As of the date of hearing, the petitioner continued to have problems with mobility and pain in his lower back. He continued to do the exercises he learned in therapy each morning, but also continued to use Ibuprofen a lot, TENS unit and Lidocaine patches for pain. (Tr. 7/17/13 @ 54-55). The petitioner usually used the TENS unit every other day, as he found it to be less effective if he used it two days in a row. Lidocaine usages is sometimes every day and sometimes every other day, which helps take the edge off the pain. (Tr. @ 55).

The petitioner's left hand remains sore and he cannot grasp anything and put pressure on it because of the pain he experiences at the base of his thumb. This makes it difficult for him to pick up anything small or button things. (Tr. 7/17/13 @ 56). The surgery on his hand performed by Dr. Urbanosky relieved his carpal tunnel pain and some of the thumb pain. (Tr. 7/17/13 @ 56). Prior to June 14, 2006, the petitioner was not experiencing any difficulties with his left wrist or left hand. (Tr. 7/17/13 @ 57).

The petitioner further explained that when he saw Dr. Bernstein, he never told him that he had shoulder or knee problems. (Tr. 7/17/13 @ 57-58).

The petitioner reviewed Respondent's Exhibit 2, which was an application for a trial return to work program from September 21, 1996. (Tr. 7/17/13 @ 62). The petitioner was on social security disability at that time and that application allowed him to go back to full time iron working for a period of 9 months before his social security would stop. (Tr. 7/17/13 @ 62-63). The petitioner explained that the social security he was receiving at that time had nothing to do with his lower back or left hand. (Tr. 7/17/13 @ 63).

On cross-examination, the petitioner testified that all of the jobs he applied to in Exhibit 22 were not hiring and agreed that nobody had denied him a job based upon any physical restrictions. (Tr. 7/17/13 @ 71).

The petitioner was involved in a dissolution of marriage proceeding in Will County in 1995. (Tr. 7/17/13 @ 72-73). As part of that litigation, the petitioner signed a settlement agreement on August 15, 1996. (Tr. 7/17/13 @ 73-74).

The petitioner applied for a trial return to work program on September 21, 1996. (Tr. 7/17/13 @ 85). The petitioner could not recall how long he had been on social security disability as of 1996. (Tr. 7/17/13 @ 86).

After an *in camera* review of records, the arbitrator stated the arbitrator finds/rules on or about May of 1991, the petitioner was eligible for social security disability and was awarded those benefits, which continued until he applied for the return to work program and returned to work. The reasons for that disability were not relevant and will not be admitted. (Tr. 7/17/13 @ 92-93).

The petitioner continued receiving social security for 9 months during the trial return to work period, then the benefits stopped and he continued iron working. (Tr. 7/17/13 @ 94-95).

The petitioner was again on social security as of the date of hearing in this matter. (Tr. 7/17/13 @ 95). From 1996 through the time that his workers' compensation benefits were cut off after the examination of Dr. Bernstein, the petitioner had not received social security benefits. (Tr. 7/17/13 @ 95-97).

From 1996 through 1999, the petitioner worked as an iron worker without restrictions. (Tr. 7/17/13 @ 97-98).

On October 21, 1999, the petitioner had a work accident in which he tripped and fell on rebar. (Tr. 7/17/13 @ 98-99). The petitioner filed a workers' compensation claim for that accident. The petitioner had two rotator cuff surgeries and a torn labrum. (Tr. 7/17/13 @ 99). The petitioner settled that case based upon a disputed wage differential in April of 2003. (Tr. 7/17/13 @ 99-100, RX 4). The petitioner returned to work as an iron worker a month or two after this settlement was approved. (Tr. 7/17/13 @ 102-103).

From the date of his accident in October of 1999 through the date of settlement, the petitioner was off work and received medical treatment. (Tr. 7/17/13 @ 106-107). The petitioner underwent a FCE in November of 2000. (Tr. 7/17/13 @ 107).

Testimony of Ron Knezevich 7/15/14

On further cross-examination, the petitioner testified that at the time of his accidents, he was an iron worker out of Local 444. (Tr. 7/15/14 @ 6-7). The petitioner explained that the health and welfare fund kept track of the number of hours he worked. (Tr. 7/15/14 @ 8). However, when shown Respondent's Exhibit 11, which included a summary of hours worked from the petitioner's pension fund, the petitioner testified that it was not a correct summary of the hours he actually worked. (Tr. 7/15/14 @ 12-13). The petitioner explained that there had been discrepancies found in his pension records before, when he retired. (Tr. 7/15/14 @ 13).

Prior to 2006, the petitioner testified that he did have two or three previous occasions where he had hurt his back. (Tr. 7/15/14 @ 18). The petitioner had sought treatment for those injuries, which he recalled being in the late 1980s, 1991 and 1997 or 1998. (Tr. 7/15/14 @ 18-20). Prior to the injuries in this case, 1998 was the last time the petitioner had sought medical treatment for his back. (Tr. 7/15/14 @ 20).

On re-direct examination, the petitioner stated that when he applied for work, he applied for places that were actually hiring. (Tr. 7/15/14 @ 25). When performing his job search, the petitioner marked the jobs he applied for to indicate whether the employer was hiring or not. After reviewing the logs, the petitioner testified that he applied to close to 280 employers who were hiring. (Tr. 7/15/14 @ 26-27).

The petitioner again reiterated that from 2003 up through his accident on June 14, 2006, he worked full duty as an iron worker. (Tr. 7/15/14 @ 36). Although the petitioner had some prior injuries and prior periods of disability, he explained that he decided to go back to work because he learned in the United States Marine Crops that you don't give up, you just keep plugging along. He served in the Marine Corps in the Viet Nam War. He also did not want to become a burden on society and he wanted to work. (Tr. 7/15/14 @ 36-37).

After his workers' compensation settlement for shoulder injuries in 2003, the petitioner explained that he was able to go back to work through extensive therapy and exercises, which built his shoulders back up to where he could handle the work again. (Tr. 7/15/14 @ 38). The petitioner had a FCE for his shoulder injuries in 2000. (Tr. 7/15/14 @ 39-40).

Testimony of Randall Starck 7/15/14

Randall Starck is employed by the respondent and has been employed by the respondent for 45 years. (Tr. 7/15/14 @ 48). Mr. Starck testified that he is familiar with the respondent's overtime policies. He stated that if there was going to be overtime, they would ask the individual if they could work it. (Tr. 7/15/14 @ 50-51). He further testified that if the worker said no, then they would not have to work the overtime. (Tr. 7/15/14 @ 51). He further testified that working Sundays was very rare and Saturdays were rare as well. If someone worked a Saturday, it would be at the overtime rate. (Tr. 7/15/14 @ 51). Mr. Starck stated that if an employee could not work overtime when asked, they were not penalized. (Tr. 7/15/14 @ 53).

On August 4, 2006, after the petitioner's thumb injury, Mr. Starck claimed that he spoke with the petitioner on the phone about returning to work. (Tr. 7/15/14 @ 54-55). Mr. Starck stated that he told the petitioner he had a job for him to go to, but claimed the petitioner did not want to return to work because he would get a small settlement after returning to work. (Tr. 7/15/14 @ 55-56). However, Mr. Starck admitted that the petitioner did agree to go back to work within the restrictions placed on his by his doctor. (Tr. 7/15/14 @ 56).

After the petitioner returned to work, Mr. Starck testified that he was assigned to tie short pieces of rebar. (Tr. 7/15/14 @ 57). However, Mr. Starck testified that he was not present on a job site at the time that the petitioner was injured on August 14, 2006. (Tr. 7/15/14 @ 65).

Mr. Starck would visit the job site periodically to observe the employees. (Tr. 7/15/14 @ 65). He testified that he spoke with the job foreman and told the foreman to help the petitioner, allow him to carry rebar with a skid-steer, and provide him with another iron worker on the job for heavier lifting. (Tr. 7/15/14 @ 67).

Mr. Starck explained that the rebar the petitioner was working with were four feet long and weighed two pounds. (Tr. 7/15/14 @ 69-70). He further stated that the bundles of rebar would be unbundled by laborers then placed in a bucket for iron workers to use. (Tr. 7/15/14 @ 73). On cross-examination, Mr. Starck testified that the petitioner's August 14, 2006 accident was reported to the respondent's workers' compensation insurance carrier. (Tr. 7/15/14 @ 75-76). It was Mr. Starck's job to report it. (Tr. 7/15/14 @ 76). Mr. Starck again clarified that he was not there when the petitioner was injured. (Tr. 7/15/14 @ 80).

Testimony of Dennis Martin 7/15/14

Dennis Martin is the president and CEO of the respondent, Martin Cement. (Tr. 7/15/14 @ 82). Mr. Martin testified that when he hires ironworkers to work at his sites, he calls the union halls and requests the number of workers that he needs. The petitioner in this case was sent to the job by his union hall in Will County. (Tr. 7/15/14 @ 85). Mr. Martin explained that he has no choice over who the union hall sends out to his jobs. (Tr. 7/15/14 @ 86). When concrete is being poured, there is a requirement that one iron worker at least be on the job site. (Tr. 7/15/14 @ 89). When the union sends a worker to the respondent, the respondent does not know whether that individual has physical limitations. (Tr. 7/15/14 @ 93).

Further Testimony of Ron Knezevich 7/15/14

On recross-examination, Mr. Knezevich clarified that when he stated there were inconsistencies in work hours shown in Respondent Exhibit 11, that was as compared to Petitioner's Exhibit 23. (Tr. 7/15/14 @ 101-102).

On redirect-examination, the petitioner testified that he had not reinjured his back or returned to work since he last testified on July 17, 2013. (Tr. 7/15/14 @ 119). The petitioner is also not currently under any medical care for his back. (Tr. 7/15/14 @ 120).

When asked about the conversation he had with Mr. Starck to come back to work at light duty on August 4, 2006, the petitioner testified that Mr. Starck had told him that he could come back at light duty and if he needed assistance with anything, the laborers would help. (Tr. 7/15/14 @ 120-121). The petitioner testified that he never spoke with Mr. Starck about a settlement when he was offered light duty. (Tr. 7/15/14 @ 121).

The petitioner agreed that each of the individual pieces of rebar he was working with weighed about 2 pounds, but when he was injured on August 14, 2006, he was trying to pick up a 10 to 15 pound bundle with one arm. The bundle got stuck in the gravel and he wrenched his back. (Tr. 7/15/14 @ 122-123). The petitioner explained that he would not request a laborer to help him pick that material up because it was small steel. (Tr. 7/15/14 @ 123).

Prior to his accident, the petitioner testified that he had worked a number of 10 hour work days during concrete pours. The petitioner explained that during a pour, you cannot leave until the pour is finished. There was no option to walk off the job after 8 hours. (Tr. 7/15/14 @ 127).

Deposition Testimony of Dr. Jerry Chow – 11/19/07

Dr. Chow is a physician who specializes in plastic surgery and hand surgery and is board certified. (PX 15 @ 4-5). He provided Dr. Chow a history of injuring his left thumb on June 14, 2006, at work. While on light duty with a brace on his left hand he injured his lower back on August 14, 2006 while lifting with his right hand. Dr. Chow diagnosed a crush injury to the left thumb leading to a trigger thumb and stenosing tenosynovitis. Options were injection or surgery and the petitioner could not work because he could not grasp with the left hand. (PX 15 @ 9). Dr. Chow did give the patient a cortisone injection into the left trigger thumb on January 2007. (PX 15 @ 10). The patient complained of numbness in the thumb. Dr. Chow ordered an EMG and sought authorization for a trigger thumb release. On February 15, 2007, Dr. Chow had an EMG performed which showed the petitioner had bilateral median neuropathy or carpal tunnel syndrome in the left thumb. On March 12, 2007, Dr. Chow noted that the petitioner had no clicking but he had tenderness at the A-1 pulley. There was a deformity of the nail and he was concerned about a fungal infection. (PX 15 @ 12-13).
Dr. Chow opined based upon a reasonable degree of medical and surgical certainly, that the thumb injury aggravated a preexisting median neuropathy leading to his carpal tunnel syndrome. He stated he has seen it many times that an injury in the hand with subsequent swelling can aggravate a carpal tunnel, aggravating median neuropathy leading to the patient being symptomatic with carpal tunnel symptoms. He explained that you have to think about carpal tunnel from the beginning. It is a pressure on the nerve. There could be many things that put pressure on the nerve and swelling is obviously a common one. In the petitioner's case he had swelling following his fractured thumb and that led to his carpal tunnel symptoms. An EMG was ordered due to the neuropraxia that was evident six months post injury. The numbness is an important part of the carpal tunnel syndrome and of course, the distribution of symptoms. If it is numbness of the fifth finger we don't think of carpal tunnel, it is his thumb, that is in the median nerve distribution. Although the petitioner had preexisting carpal tunnel, there was no carpal tunnel symptoms in the right hand.

At the time of the deposition, the petitioner was waiting to have the surgery, including release of the trigger thumb, remove the nail to treat the fungal infection, and release the pressure on the median nerve on the carpal tunnel in the left hand. He had not been released to work. It was Dr. Chow's opinion that the trigger thumb release, median nerve release, and the removal of the nail bed, were all related to the accident of June 14, 2006. Dr. Chow had ruled out other causes such as diabetes, high blood pressure that cause carpal tunnel. (PX 15 @ 14-20).

On cross examination, Dr. Chow explained that swelling in the thumb came down to the wrist and caused pressure on the median nerve. The median nerve supplies the thumb, index and long finger of the hand and half of the ring finger. (PX 15 @ 22-23). He agreed that the injury did not cause the underlying median neuropathy, it simply made it symptomatic. Dr. Chow further explained that the petitioner had declined having one surgery just to the thumb and then a separate surgery for the carpal tunnel. He wanted all surgeries at one time and the doctor agreed with the petitioner in that decision. (PX 15 @ 28-29). As of the date of the deposition, the petitioner was cleared to work one-handed light duty work only with the right hand. (PX 15 @ 31). Dr. Chow opined that the petitioner does not have carpal tunnel symptoms in the right hand. (PX 15 @ 39). He technically has a median neuropathy in the right hand.

Dr. Chow further explained on redirect examination that he was not recommending splinting of the hand because of the fact that the petitioner had numbness in his thumb 24 hours a day, 7 days a week. Page (PX 15 @ 40-41).

Deposition Testimony of Dr. Thomas Wiedrich – 1/24/08

Dr. Wiedrich is a hand surgeon who has practiced since 1992. (RX 10 @ 4-5). Dr. Wiedrich reviewed the records and reports of Dr. Chow and the occupational therapy notes from Will County Medical Associates, Dr. Cohen's office notes, some physical therapy notes and EMG. (RX 10 @ 9-10).

Dr. Wiedrich diagnosed the petitioner with a crush injury to the tip of the left thumb with some tenderness and subjective numbness over the tip of the thumb, as well as trigger thumb or stenosing tenosynovitis of the left thumb. (RX 10 @ 12). Dr. Wiedrich testified that with the crush type injury one can get localized swelling in the area of the thumb that can cause a triggering of the tendon of the thumb, as it slides through the system it holds the tendon in place. He believed the petitioner's trigger thumb was related to his work accident. (RX 10 @ 12-13). At the time of his examination on December 12, 2006, Dr. Wiedrich would have limited the patient to lift 10 to 15 pounds maximum and no climbing ladders over a height of 4 feet. (RX 10 @ 14).

Dr. Wiedrich also reviewed the reports of Dr. Chow recommending carpal tunnel surgery. Dr. Wiedrich was of the opinion there is no relationship between the carpal tunnel condition of the left hand and the accident. On his review of the records the patient complained of numbness at the tip of the thumb that was injured and there were no classic carpal tunnel type complaints. The injury was isolated to the left thumb and no actual injury to the hand occurred.

On cross examination Dr. Wiedrich agreed that the injury caused stenosing tenosynovitis and again would cause swelling where the thumb meets the hand, not where the thumb meets the wrist.
Dr. Wiedrich further testified that he cannot recall in 16 years of medical practice ever treating an individual with a crush injury to a fingertip for aggravation of carpal tunnel syndrome. (RX 10 @ 21). Dr. Wiedrich further argued against performing the carpal tunnel surgery, contending that it was simply a thumb injury and that the positive EMG does not prove that the condition of the thumb, which involved a crush injury, would be related to carpal tunnel syndrome. (RX 10 @ 23-24). Dr. Wiedrich contended that it was impossible for the distal thumb injury trauma to have aggravated carpal tunnel syndrome. (RX 10 @ 25).

Deposition Testimony of Susan Entenberg – April 7, 2011

Susan Entenberg is a vocational counselor who works with individuals who have some degree of impairment, be it mental, physical or a combination of both, to provide whatever rehab services to return them to their maximum level of functioning. She has worked with the industrially injured in the state of Illinois since 1977. (PX 16 @ 3-4). Ms. Entenberg testified that the petitioner graduated high school and attended Joliet Junior College on and off. He took some classes between the 1970s and 1990s. He has no degree or certificate. He thinks he may have 50 credit hours over the years. The petitioner has a solitary work experience as an iron worker, which began in 1978 as a member of Local 444. That is the only work he has ever done. Ms. Entenberg explained that iron work is heavy work where you are placing and raising structural steel members to form frameworks. The work involves placing, fastening, guiding, and welding iron, along with climbing scaffolds, working at heights and working in dangerous situations. (PX 16 @ 6-8).

Ms. Entenberg reviewed her knowledge that the petitioner was injured at work on June 14, 2006. He injured his left thumb and went to the emergency room and was then provided light duty work. Then he injured his lower back on August 14, 2006. He was seen by Dr. Komanduri, Dr. Herzonsky, and Dr. Urbanoski who did a left carpal tunnel release and left trigger thumb release in August of 2008.

A functional capacity assessment in January of 2009 released him with restrictions of medium level lifting and limited ladder climbing, while noting decreased strength and dexterity of the left hand.

Ms. Entenberg opined that he could not return to work as an ironworker within his restrictions. The opinion was based upon the functional capacity evaluation and the restrictions outlined which placed the petitioner at the medium duty physical demand level. (PX 16 @ 9).

According to Ms. Entenberg, as of the date of her first meeting with the petitioner, even though he could not perform ironwork, he did maintain enough physical capacity to do other jobs. She opined that he could be a welder, machine operator, building maintenance, supply house clerk, with wages between $10.00 and $15.00 per hour. Ms. Entenberg noted that there were some negative factors, including his age of 60 and the fact that he has only worked as an ironworker his entire life. He does not have other skills, but could likely perform work at the entry level jobs she mentioned. Based on the Illinois Department of Employment security statistics the average median wage was between $10.00 and $15.00 per hour, which is his earning capacity.

Following her initial assessment, Ms. Entenberg generated a second report dated October 30, 2010. (PX 16 @ 10-11). At that time, Ms. Entenberg reviewed petitioner's job search logs from the time she had first met with him through October of 2010, as well as the reports and job search logs from Genex. She opined that, based upon the diligent job placement efforts that had been performed to date without any success, there was no stable labor market available to the petitioner. Ms. Entenberg went on to opine that, if the petitioner were able to find work within his restrictions, she still believed he would be able to earn $10.00 to $15.00 an hour. (PX 16 @ 11-12).

At the time of her testimony, Ms. Entenberg also reviewed additional job search lobs through March of 2011. After reviewing those logs, Ms. Entenberg felt that the petitioner was doing a good job in his search. He was trying, but Ms. Entenberg felt that there were simply no jobs out there. Ms. Entenberg also reviewed the report of Dr. Avi Bernstein which indicated that the petitioner can work within the parameters of the functional capacity assessment.

During cross examination, Ms. Entenberg testified that her past research indicated iron working foremen and supervisors are still doing a lot of work. (PX 16 @ 19-20). She has not found the opportunities for light duty within the ironworker union. (PX 16 @ 21).

When asked about the petitioner's disability pension from 1996, Ms. Entenberg testified that it was 2010 and information from 2010 when she interviewed the petitioner was what was important. (PX 16 @ 24).

Deposition Testimony of Dr. Avi Bernstein – 7/14/11

Dr. Bernstein testified he is a board certified orthopedic surgeon. He is fellowship trained in spine surgery and restricts his practice to conditions of the spine. He performs 250 to 300 spine operations a year. He sees thousands of patients a year for all kinds of conditions related to the neck and lower back. (RX 9 @ 4-5).

Dr. Bernstein had no independent recollection of the petitioner. (RX 9 @ 6). The petitioner did report to Dr. Bernstein the injury of the lower back and explained his medical care consistent with the medical records. Dr. Bernstein performed an examination of the petitioner's lumbar spine and found it to be normal.

According to Dr. Bernstein, the degenerative changes shown on the petitioner's MRI from November 14, 2008, were typical and consistent with his age. He had more degenerative involvement at L5-S1 and there was a central protrusion. No disk herniation and no nerve root compression. (RX 9 @ 8-10). Dr. Bernstein also reviewed the petitioner's functional capacity evaluation which indicated he was functioning at a medium physical demand level on February 3, 2009. Dr. Bernstein diagnosed routine degenerative condition of the petitioner's lumbar spine and opined that he did not require any further medical treatment. Dr. Bernstein believed that the petitioner could work and that he could function within the parameters of the 2009 functional capacity evaluation. (RX 9 @ 9-11).

Dr. Bernstein further opined that the petitioner's physical limitations could not be attributed to his work accident. He stated that petitioner had a degenerative condition that bothers him from time to time and multiple joint involvement in terms of another arthritic condition, which contributed to his functional limitation. It is Dr. Bernstein's opinion that he would not restrict the petitioner from iron work on the basis of the lower back but would restrict him from work based on all his diffuse complaints, including his prior shoulder surgeries, knee surgeries, and other issues. (RX 9 @ 11-12).

Dr. Bernstein contended that any restrictions the petitioner presently had were unrelated to the work injury of August 2006. (RX 9 @ 12-13).

During cross-examination, Dr. Bernstein admitted that he had four reports in his chart from Dr. Edward Goldberg from Dr. Goldberg's Section 12 exams. Dr. Bernstein further testified that he was performing 100 to 200 exams per year or 2 to 4 exams per week; 70 to 80 percent of which for insurance companies or employers. (RX 9 @ 15-17).

Dr. Bernstein agreed that ironwork is considered heavy work. Dr. Bernstein contended that the petitioner told him his bilateral shoulder condition and knee conditions from years prior are preventing him from being an ironworker, even though none of that information was contained in his chart or in his medical report. (RX 9 @ 18-19). There is no signed document, no tape recording, and no written statement from the petitioner to that effect. Dr. Bernstein claimed that he drew that conclusion based on the history that the petitioner gave him at the time of his examination. (RX 9 @ 18-20).

Dr. Bernstein agreed that based on the February 12, 2009 opinion of Dr. Urbanosky, she did place restrictions on the petitioner based on the thumb injury. Dr. Urbanosky recommended that the petitioner should be restricted from ironwork and he should be retrained.

Dr. Bernstein agreed that the petitioner should have permanent restrictions. He did not examine the petitioner's hand. On reviewing the functional capacity evaluation with Dr. Bernstein from January 2009, Dr. Bernstein agreed that the FCE restricted him from performing the duties of an iron worker and certain exercises were not performed due to flare-up of back and muscle spasms. The FCE therapist also states the petitioner was unable to meet above-shoulder requirements of an ironworker due to back pain and muscle spasm. So in reviewing the functional capacity evaluation, Dr. Bernstein agreed it would be fair to state that the lower back was a major factor in restricting the petitioner's activities. (RX 9 @ 24-26).

Dr. Bernstein was asked the following question: "Knowing that the lower back is a factor in restricting his activities, would you agree that there is then a relationship, a causal relationship, between his lower back injury of August 14, 2006, and the physical restrictions imposed in January 2009?" Answer: "Yes." (RX 9 @ 26).

In Dr. Bernstein's chart are the four reports of Dr. Edward Goldberg that repeatedly state the petitioner, that the August 14, 2006, accident aggravated a prior degenerative disk disease of the petitioner. Dr. Bernstein was asked if the, now that he had a chance to look at Dr. Goldberg's reports, would he agree that the position of Dr. Goldberg is a reasonable position, Dr. Bernstein answered, "It is a reasonable position if you feel that the patient's chronic subjective complaints are representative of his true situation, yes."

On re-direct examination, Dr. Bernstein agreed it was his opinion that the petitioner is not restricted from returning to work as a result of his 2006 accident. Dr. Bernstein further testified that he could not specifically relate the petitioner's restrictions to the 2006 accident. (RX 9 @ 35).

On re-cross-examination, Dr. Bernstein agreed that the petitioner's 2009 FCE restrictions would prevent him from returning to iron work and that Dr. Goldberg's opinions relating the petitioner's 2006 accident to an aggravation of his preexisting lumbar degeneration were reasonable. (RX 9 @ 36-37). Dr. Bernstein concluded by agreeing that there could be a causal relationship between the August 2006 work accident and the restrictions imposed on the petitioner in January of 2009. (RX 9 @ 37).

Deposition Testimony of Dr. Edward Goldberg – 1/9/12

Respondent's examining physician, Dr. Edward Goldberg of Midwest Orthopedics at RUSH testified on January 9, 2012 pursuant to dedimus potestatem requested by petitioner's attorney. (PX 17 @ 4). Dr. Goldberg is an orthopedic surgeon with specialty in the spine who is part of Midwest Orthopedics at Rush. He performs 8 to 10 IMEs per week. The bulk of them are at the request of the employer -respondent.

Dr. Goldberg testified that he first examined the petitioner on behalf of Zurich in January of 2007. When he examined the petitioner, the petitioner described sustaining his lower back injury. Dr. Goldberg diagnosed degenerative disk disease of the lumbar spine and opined that the petitioner likely aggravated the preexisting degenerative disk disease of the lumbar spine in his work accident. Dr. Goldberg stated that the petitioner could return to work with a 10-pound lifting restriction. (PX 17 @ 6-7).

Dr. Goldberg drafted another report to Zurich in April of 2007, in which he explained again that there was an aggravation of a preexisting degenerative disk and recommended work hardening. He also recommended that the petitioner stay on a 10-pound lifting restriction. (PX 17 @ 7-8).

On March 31, 2008 Dr. Goldberg produced another report in this case. At that time, Dr. Goldberg was still of the opinion that the petitioner was suffering from an aggravation of degenerative disk disease of the lumbar spine and he recommended a work capacity assessment. Dr. Goldberg related the aggravation to the petitioner's accident of August 14, 2006. (PX 17 @ 9).

Dr. Goldberg produced yet another report on May 18, 2009, which was in response to a letter from the respondent's attorney but addressed to the claims representative at Zurich, the respondent's workers' compensation insurance company. In this report, Dr. Goldberg again indicated there had been an aggravation of degenerative disk disease. He stated there was a valid functional capacity assessment which allowed the petitioner to function with a maximum one-time lift of 60 pounds, lift 50 pounds frequently, and noted that the petitioner could not climb letters.

He indicated the petitioner could not perform the duties of an ironworker and he reiterated that the petitioner had aggravated the degenerative disk from the work-related accident. (PX 17 @ 11-12).

On October 7, 2011, Dr. Goldberg had a meeting with the respondent's attorney, Mr. Paul Coughlin. It was Dr. Goldberg's testimony that Mr. Coughlin arrived with three boxes of documents, hundreds of pages of records, however left no documents with Dr. Goldberg. Dr. Goldberg stated that he reviewed a document from the social security administration from year 1992 stating the patient is disabled. He agreed that this document is not a medical record. He looked at a document entitled Application for Trial Work Program on October 5, 1996, indicating the patient wished to attempt to return to work. He agreed it is not a medical record. Dr. Goldberg also reviewed a settlement contract dated April 16, 2003. The settlement contract was for the right and left shoulder. Finally, Dr. Goldberg looked at a functional capacity exam from November 8, 2000, which placed the patient in a light-medium, 35-pound lifting restriction in the year 2000. In addition, Dr. Goldberg reviewed divorce documents from the divorce of the petitioner. He stated that he changed his opinion based on the FCE. Dr. Goldberg had indicated he saw no other records indicating the patient was ever released to full duty status as an ironworker when he met with Mr. Coughlin. (PX 17 @ 16-23).

On further examination, Dr. Goldberg was shown medical records from Dr. Komanduri, Dr. Sarcu, Dr. Nedkarni, and Joliet Medical Group for treatment 2003 through 2006. Dr. Goldberg also reviewed the detailed report from Mid America Funds which shows the reported hours that the petitioner worked as an iron worker from 2003 through 2006. In the year 2003 he worked 628 hours, 2004: 1,185.88 hours, 2005: 735.50 hours, and 2006: 436.50 hours. After reviewing these records, the doctor was asked to assume that the petitioner did return to ironworker duties from 2003 to 2006 and that he performed the heavy duties of an iron worker during that time, and that he worked the hours reported. (PX 17, Exhibits 6, 7, 8, 9, 10, and 11 which is the Mid America Funds records of work hours reported.)

Dr. Goldberg was further asked, "The question is then, would you then agree to go back to your original opinion, that the injury causing an aggravation of the degenerative disk as you stated originally, now that you have seen these additional records?" Answer: "The question is yes."

Question: "And could you explain why?" Answer: "Well, he apparently was working as an ironworker throughout." (PX 17 @ 33). None of these documents were shown to Dr. Goldberg by Mr. Coghlan when he met with Dr. Goldberg on October 7, 2011.

Question: "Is it your opinion, doctor, based upon a reasonable degree of medical and surgical certainty, that the August 14, 2006, accident was a cause of his lower back condition leading to an aggravation of his degenerative disk disease?" Answer: "I would say that, yes."

Dr. Goldberg further agreed that the petitioner's restrictions are at least in part related to the accident of August 14, 2006. He also agreed after taking all the records into consideration, that his inability to return to work as an ironworker is related to his accident of August 14, 2006. (PX 17 @ 33-36).

On cross-examination, Dr. Goldberg was handed a settlement contract, a social security document, a trial work program request, and a FCE to review. After reviewing these records, Dr. Goldberg stated that the apparently, as of year 2000, the petitioner had restrictions in terms of returning to full duty as an ironworker. (PX 17 @ 45).

On re-direct examination, the doctor was asked question: "If he for three years had performed regular duties of an ironworker from 2003 to 2006, then if I'm understanding you correctly, it would be your opinion that the August 2006 accident was the cause of the lower back injury and his inability to be an ironworker. Is that my understanding?" Answer: "If he again, I can't say he was working full-time." Question: "Of course you can."

Answer: "If that were the case, then yes." However, if the petitioner had not been working at full duty, but rather light duty from 2003 to 2006, then it would be his opinion that the 2006 injury did not lead to the petitioner's current restrictions. (PX 17 @ 48).

So the key according to Dr. Goldberg was the level of activity of the petitioner when he returned to work, and whether he performed full duty as an ironworker. (PX 17 @ 49-50, 56-57).

Deposition of Dr. Mukund Komanduri – 5/24/12

Dr. Komanduri is an orthopedic surgeon. He has been practicing in the Will County area since 1994. He is board-certified in orthopedics. (PX 14 @ 4-6). Per dep exhibit he was educated at University of Chicago. Dr. Komanduri treated the patient for knee injury and a shoulder injury in the year 2002 and he had an uneventful recovery from the knee and shoulder injury. Dr. Komanduri reviewed his April 9, 2003, note where the petitioner had "shoulder care" and the petitioner had full range of motion, good strength and good mobility, and was released from Dr. Komanduri's care. He was released to full duty as an ironworker and there was no intent to restrict him. He had no complaints. He was doing well. (PX 14 @ 8-10).

Dr. Komanduri also reviewed his December 29, 2003, office note which indicated that the petitioner had neck strain from a motor vehicle accident and it resolved with physical therapy. He was released to full activity and released from Dr. Komanduri's care with no work restrictions. (PX 14 @ 11-12).

Dr. Komanduri next saw the petitioner for his lower back injury following the petitioner's August 14, 2006 accident. The petitioner gave a history of working light duty, bending over to pick up something with his right hand, and hearing a loud pop in his lower back, causing severe discomfort in the back.

Dr. Komanduri referred the petitioner to Dr. Hersonsky for evaluation, who concluded it was a non-surgical lower back condition, and Dr. Edward Goldberg also concluded it was a non-surgical lower back condition. Dr. Komanduri noted that the petitioner's MRI demonstrated degenerative disk disease and a small disk herniation.

The petitioner eventually underwent a FCE in 2009 which restricted him to medium duty. Dr. Urbonosky released the petitioner to return to work within the limits of the FCE. (PX 14 @ 15-19).

Dr. Komanduri concluded there was an aggravation of the petitioner's lower back that left him with a deficit that was not correctible, which he opined was causally related to the petitioner's work injury of August 14, 2006. (PX 14 @ 19-20). Dr. Komanduri was in agreement with the restrictions that were imposed by the 2009 functional capacity assessment. It was Dr. Komanduri's opinion that the physical restrictions from the functional capacity evaluation were causally related to the accident of August 14, 2006. (PX 14 @ 20-21).

Regarding Dr. Goldberg's opinions, Dr. Komanduri agreed with Dr. Goldberg's opinions that there was an aggravation of the petitioner's lumbar spine, that he was appropriately treated conservatively, and that he should be restricted based upon the results of the FCE. (PX 14 @ 22).

On cross-examination, Dr. Komanduri agreed that in September 2002 the patient did have some restrictions. In addition, on November 8, 2000, the petitioner had light to medium restriction, according to an FCE.

Petitioner told Dr. Komanduri he was back at work full duty prior to 2006. (PX 14 @ 34).

On re-direct examination, Dr. Komanduri stated his opinions e did not change and were based on the medical information that he has and the chart notes and literature that he has, which support his opinions. Dr. Komanduri had no information that would indicate the petitioner was not working full duty from 2003 to 2006 as an ironworker. (PX 14 @ 44-45). (emphasis added due to double negative).

CONCLUSIONS OF LAW

I. On the issue of whether an accident occurred that arose out of and in the course of petitioner's employment by respondent, (C), the arbitrator hereby finds:

Based upon the totality of the evidence, The arbitrator hereby finds as a matter of fact and law that the petitioner did sustain and accident which arose out of and in the course of his work for respondent on August 14, 2006.

Having underwent hours and hours of both organized direct exam and inciteful, quite probative cross exam this petitioner is deemed credible with consistent testimony to the records. This Arbitrator dismisses Dr. Bernstein alleged history in part noted above. He credibly testified that after sustaining a thumb injury on June 14, 2006, he returned to work with restrictions on August 4, 2006. (Tr. 7/17/13 @ 24). This testimony is supported by the medical records from Dr. Cohen, which indicate that the petitioner was cleared to return to work with restrictions of no lifting greater than 15-20 pounds with the left upper extremity, no climbing, and use of thumb splint as needed on July 27, 2006. (PX 9). Mr. Starck, who testified on behalf of the respondent also testified that the petitioner went back to work on August 4 within the restrictions placed on him by his doctor. (Tr. 7/15/14 @ 56). Morever, the Arbitrator infers that not all the recordation of wages earned made their way to the pension system.

In summary as noted above, on August 14, 2006, the petitioner testified that he was picking up some dowels, which were three foot long pieces of rebar lying in a pile, partially covered with gravel. Around the dowels was a number 9 wire. (Tr. 7/17/13 @ 26). The petitioner explained that when he used his right hand to try to grab the bundle, it was stuck and as he attempted to pull the bundle up, he felt a snapping sensation in his lower back with pain into the legs. (Tr. 7/17/13 @ 26-27).

A review of the medical records shows that the petitioner's accident history has been consistent throughout his treatment. On August 15, 2006, the petitioner was seen at Adventist Midwest Health and explained that he sustained a lower back injury while lifting rebar at work. (PX 12). When the petitioner first saw Dr. Komanduri on August 21, 2006, he also explained to Dr. Komanduri that he was injured when picking up bars of iron, which he estimated weighed about 15 pounds. (PX 1). Similar accident histories are contained in the records of Dr. Goldberg and Dr. Hersonskey, as well as in the petitioner's physical therapy records. (PX 2, PX 13, PX 17). There is no indicia in the record which contradicts the petitioner's accident history.

In disputing accident in this case, the respondent offers only the testimony of Mr. Starck, a 45 year employee of Martin Cement essentially that the mechanism of injury alleged could not have existed because rebars are to be unbundled by labors. (Tr. 7/15/14 @ 48). Mr. Starck testified that the rebar the petitioner was working with was supposed to be unbundled by laborers and placed in a bucket for the iron workers to use. (Tr. 7/15/14 @ 73).

He also testified that the rebar the petitioner was supposed to be working with was 4 feet long and weighed 2 pounds. (Tr. 7/15/14 @ 69-70).

However, importantly, Mr. Starck admitted that he was not on the job site on August 14, 2006 when the petitioner was injured. (Tr. 7/15/14 @ 65). Also, after the accident was reported to Mr. Starck, he reported it to the respondent's workers' compensation carrier, as that was part of his job. (Tr. 7/15/14 @ 75-76).

The testimony of Mr. Starck did not contradict that of petitioner. It was incomplete in terms the total works of the Petitioner but agreed with a limited segment. As stated and agreed one piece of the rebar weighed 2 lbs. Petitioner never said he picked up one piece of 2 pound rebar. Petitioner agreed one piece weighs two pounds. The petitioner picked up a bundle of rebar that was stuck in gravel with his non injured hand and injured the lower back. Mr. Starck was not on the job site at the time of the petitioner's injury and Mr. Starck admitted that the petitioner would have been working with rebar on the date of his accident.

Clearly, the version of events depicted by the petitioner at trial and to each of his medical providers was consistent, very logical in terms of the bundle of rebar, job site condition, extremely credible, and not contradicted

Therefore, the arbitrator finds as a matter of fact and as a conclusion of law petitioner in the case at bar did sustain an accident that arose out of and in the course of his employment by respondent on August 14, 2006 .

I. On the issue of whether the petitioner's current condition of ill-being is causally related to his work injury, (F), the arbitrator hereby finds:

Based upon the totality of the evidence,, the arbitrator hereby finds that the current condition of ill-being in the petitioner's lumbar spine, including the aggravation of degenerative disc disease, disc herniation and permanent restrictions related thereto, are causally related to his August 14, 2006 work accident.

The arbitrator hereby adopts the well reasoned opinions of Dr. Edward Goldberg (respondent's Section 12 examiner) and Dr. Mukund Komanduri regarding the causal relationship between the petitioner's August 14, 2006 accident and the current condition of ill-being in his lumbar spine.

Dr. Komanduri was the petitioner's treating physician immediately after his August 14, 2006 work accident. Dr. Komanduri opined that there was an aggravation of the petitioner's lower back on August 14, 2006 that left him with a deficit that was not correctable and, therefore, his current condition of ill being was causally related to the August 14, 2006 work accident. (PX 14 @ 19-20). Dr. Komanduri also opined that the petitioner's physical restrictions, as outlined by the 2009 FCE were causally related to his August 14, 2006 work accident. (PX 14 @ 20-21).

In addition to the opinion of Dr. Komanduri, Dr. Goldberg examined the petitioner on a number of occasions throughout his treatment and had the opportunity to review medical records related to the petitioner's treatment with other physicians in this case. Dr. Goldberg opined repeatedly that the petitioner sustained an aggravation of degenerative disc disease on August 14, 2006 and that his current condition of ill-being was causally related to that accident. Dr. Goldberg rendered this opinion in January of 2007, April of 2007, March of 2008, May of 2009, and at his deposition in January of 2012. (PX 17 @ 6-7, 7-8, 9, 11-12, and attached to the deposition are Exhibits 1, 2, 3 & 4). Dr. Goldberg explained that the petitioner had been working full duty as an iron worker

prior to August 14, 2006 and that the August 14, 2006 accident caused his back to become problematic and painful. Dr. Goldberg further opined that the petitioner's restrictions and inability to work as an iron worker was related to his accident of August 14, 2006. (PX 17 @ 33-36). According to Dr. Goldberg, it was the level of activity that the petitioner was performing as an iron worker prior to August 14, 2006 on which he based his opinion. (PX 17 @ 56-57).

In reviewing the evidence in this case, it is unrebutted that the petitioner was working in a full duty capacity as an iron worker from 2003 through June 14, 2006 when he sustained his left thumb injury. (Tr. 7/17/13 @ 10). The evidence reflects that the petitioner worked 2,985 hours of full duty iron work during that period of time. (PX 23).
The respondent in this matter presented a pension credit document which also details some hours that the petitioner worked. However, the petitioner credibly testified that when the pension document produced by the respondent was incorrect, explaining that there had been discrepancies found in his pension records before. (Tr. 7/15/14 @ 12-13). In reviewing Respondent's Exhibit 11 and Petitioner's Exhibit 23, the arbitrator finds that Petitioner's Exhibit 23 is a more reliable source of information concerning the hours worked by petitioner leading up to his 2006 work accidents. To begin, respondent's exhibit only runs into the year 2004, rather than proceeding to 2006, so the Commission cannot tell by that exhibit what hours the petitioner worked prior to his accidents. Furthermore, all pension credit dates prior to 2003 are irrelevant to this case. What is relevant are the hours detailed by Petitioner's Exhibit 23, which are all of the hours worked by the petitioner from 2003 through his injuries in 2006, which was the basis of Dr. Goldberg's opinion. That document clearly reflects that he petitioner worked 2,985 hours as an iron worker during that time period. There is no evidence or testimony in the record to dispute the fact that the petitioner's work from 2003 to 2006 was at a full duty work capacity Upon review of the PX 23 it demonstrates petitioner worked for the respondent, Martin Cement, as an iron worker between 2003 and 2006. Absent from the testimony of Mr. Starck and Mr. Martin was any suggestion by them that petitioner was not performing the full duties of an iron worker when employed by Martin Cement.

The respondent disputes the causal connection between the petitioner's August 14, 2006 work accident and the current condition of his lumbar spine through the testimony of its Section 12 examiner, Dr. Avi Bernstein. Although Dr. Bernstein agreed that the petitioner should be limited to physical activity within the restrictions from his February 2009 FCE, he denied that those restrictions would be related to the petitioner's August 14, 2006 work accident. (RX 9 @ 11-12). However, after reviewing Dr. Bernstein's reasoning in this case, the arbitrator finds his opinion completely unreliable and totally non-persusaive.

Dr. Bernstein testified that the petitioner had told him that shoulder and knee conditions prevented him from returning to work as an iron worker. (RX 9 @ 18-19). However, that information was not contained anywhere in Dr. Bernstein's report and at no point in the petitioner's medical records does he receive treatment for any knee or shoulder condition that Dr. Bernstein pointed too. There is no evidence in any record that petitioner was suffering from shoulder and knee problems at the time of the visit with Dr. Bernstein, and there is no evidence from 2003 through the date of Dr. Bernstein's appointment that the knees and shoulders interfered with petitioner's ability to work. The petitioner denied he complained to Dr. Bernstein about his knees and shoulders.

Dr. Bernstein's opinions also took a different direction during cross examination. He agreed that the petitioner's lower back was a major factor restricting his activities during his FCE, then agreeing that since the lower back was a factor restricting the petitioner's activities during the FCE, there was a relationship between his lower back injury on August 14, 2006 and the restrictions imposed on him in 2009. (RX 9 @ 26).

Finally, Dr. Bernstein agreed that Dr. Goldberg's opinion that the August 14, 2006 accident aggravated the prior degenerative disk disease in the petitioner "if you feel that the patient's chronic subjective complaints are representative of his true situation." The arbitrator does find that the petitioner's subjective complaints parallel his findings. None of the various treating doctors nor Dr. Ed Goldberg at RUSH, at least, deemed this U.S. Marine Corps Viet Nam war veteran, in jargon a "devil-dog" –to now be a "dogger" in WC claims jargon.

III. On the issue of average weekly wage, (G), the arbitrator hereby finds:

At trial, the petitioner testified that following his June 14, 2006 injury, he returned to work for the respondent on August 4, 2006 and worked five 10 hours days and an 8 hour day prior to being injured again on August 14, 2006. (Tr. 7/17/13 @ 15).

The petitioner testified as to the hours he worked in August 2006 for the respondent, explaining that any work above 8 hours in a day and work on Saturdays was overtime, which was mandatory. (Tr. 7/17/13 @ 18-19). All overtime was paid at double time. (Tr. 7/17/13 @ 20). If the petitioner refused to do the overtime work, he testified that the respondent would get someone else to do the work and he could be brought up on charges from his local. (Tr. 7/17/13 @ 20-21).

Mr. Starck, who testified on behalf of the respondent, claimed that all overtime for the respondent was voluntary and that any employee who could not work overtime when asked would not be penalized. (Tr. 7/15/14 @ 51, 53). However, the petitioner explained that during a concrete pour, you cannot leave until the pour is finished. There was no option to walk off the job after 8 hours during a pour. (Tr. 7/15/14 @ 127). Mr. Martin, the President and CEO of Martin Cement, also testified that it was required for an iron worker to be on the site at all times during a concrete pour. (Tr. 7/15/14 @ 89). The inability to walk away during " a pour" is the tipping point.

After reviewing the evidence and testimony in this case, the arbitrator finds that the overtime hours worked by the petitioner for the respondent were in fact mandatory hours. The petitioner's testimony that he was not permitted to leave a concrete pour during the pour, requiring him to often work over 8 hours in a day is credible.

Based upon all evidence and testimony in this case, including the pay records contained in petitioner's exhibit 19, the arbitrator calculates the petitioner's Section 10 average weekly wage as follows:

Period Ending	Gross	O.T.Prem	Hours	Days	Wks	Wage
4/23/06	$245.20	$0.00	8.00	1.00	0.20	$245.20
6/18/2006	$544.00	$16.00	16.50	2.00	0.40	$528.00
8/6/2006	$656.00	$256.00	12.50	2.00	0..40	$400.00
8/13/2006	$2,550.00	$626.60	59.00	6.00	1.00	$1,923.40
Totals	$3,995.20	$898.60	96.00	11.00	2.00	$3,096.60

TOTAL EARNINGS UNDER SECTION 10:	$3,096.60
NUMBER OF WEEKS AND PARTS THEREOF WORKED:	2.00
SECTION 10 AVERAGE WEEKLY WAGE:	$1,548.30
TEMPORARY TOTAL DISABILITY RATE	$1,032.20

The arbitrator hereby finds as a matter of fact and law that the petitioner's average weekly wage, pursuant to Section 10 of the Act, was $1,548.30 per week.

II. On the issue of unpaid medical services, (J), the arbitrator hereby finds:

As detailed above and in consolidated case number 06 WC 47051, the petitioner's current conditions of ill being in his left thumb, left wrist and lower back are causally related to his June 14, 2006 and August 14, 2006 work accidents, respectively.

In addition, the records of Dr. Chow, Dr. Urbanosky and Dr. Wiedrich indicate that the treatment provided to the petitioner for his trigger thumb and left thumb nail bed fungal infection, including therapy, injections and a trigger thumb release surgery with excision of the nail bed and debridement of the fungal infection, have been reasonable and necessary. (PX 7, PX 8, RX 10). The testimony of Dr. Chow further indicates that the treatment for the petitioner's left carpal tunnel syndrome was reasonable and necessary.

Furthermore, the arbitrator finds from a review of the records of Dr. Komanduri, Dr. Hersonskey, Dr. Goldberg and Dr. Wilson that all care and treatment for the petitioner's lumbar spine condition has been reasonable and necessary. No physician in this case has suggested that any of the conservative treatment provided to the petitioner for his lumbar spine has been unreasonable or unnecessary.

Based upon the above findings, the arbitrator hereby orders respondent to pay outstanding medical as follows:

Provider	Beginning	Ending	Total Charges	WC Paid	ADJ. W/O	Balance
Dr. James Wilson	11/21/2006	12/19/2006	$3,069.00	$0.00	$0.00	$3,069.00
Health Benefits	9/12/2011	8/9/2012	$855.36	$0.00	$0.00	$855.36
Hinsdale Orthopaedics	6/13/2008	8/14/2008	$7,069.36	$1,511.93	$2,904.88	$2,652.55
IPM	5/23/2008	8/9/2012	$558.13	$254.34	$0.00	$303.79
IWP	1/24/2011	9/16/2011	$2,586.77	$0.00	$0.00	$2,586.77
Provena St. Joseph	6/14/2006	8/28/2006	$1,881.83	$1,489.61	$269.14	$123.08
Silver Cross Hospital	8/14/2008	8/14/2008	$7,906.70	$0.00	$0.00	$7,906.70
Totals			**$23,927.15**	**$3,255.88**	**$3,174.02**	**$17,497.25**

The arbitrator hereby orders respondent to pay to the Petitioner and his attorney reasonable and related medical expenses in the amount of $17,497.25 pursuant to Section 8(a) and 8.2 of the Act. The Arbitrator found in the companion case 06 WC 47052 that the carpel tunnel condition is not related. However, it was released at the same time and during the same surgery as the repair to the thumb.

III. On the issues of temporary total disability and maintenance benefits, (K), and the nature and extent of the petitioner's disability, (L), the arbitrator hereby finds:

Based upon the totality of the evidence , the arbitrator hereby finds as a matter of fact and law that the petitioner is due temporary total disability benefits from August 15, 2006 through February 12, 2009.

Following the petitioner's lower back injury on August 14, 2006, he was placed on an off work status at Adventist Health on August 15, 2006. (PX 12).The petitioner then followed up with Dr. Komanduri, beginning on August 21, 2006, who kept the petitioner on an off work status. (PX 1).In addition to being kept off work by Dr. Komanduri, the petitioner continued to follow up with Dr. Cohen and Dr. Chow for his hand injury, each of whom recommended that the petitioner stay off work. (PX 7, PX 9). Later the petitioner was kept off work by Dr. Urbanosky for his thumb injury as well. (PX 8).

Even the respondent's section 12 physicians, Dr. Wiedrich and Dr. Goldberg kept the petitioner on light duty restrictions. (PX 17, RX 10). There is no evidence that any light duty work was offered by the respondent.

The petitioner remained on very light or off work restrictions from each of the physicians involved in this case through the performance of the FCE on January 30, 2009. The FCE indicated that the petitioner could function at a medium physical demand level with 60 pounds maximum lift and 50 pounds frequent lift due to lower back pain. (PX 5).Following the FCE, the petitioner was placed on permanent physical restrictions by Dr. Urbanosky on February 12, 2009, consistent with the FCE results. (PX 8). Dr. Goldberg and Dr. Wiedrich each later concluded that the petitioner's work should be limited by the results of the FCE. (PX 17, RX 10).

There is no real dispute that the petitioner was on restrictions which prevented him from returning to work from August 15, 2006 through February 12, 2009. The respondent's dispute of temporary total disability benefits was based upon its disputes regarding accident and causation. However, as the arbitrator has found that the petitioner did sustain an accident that arose out of and in the course of his employment by respondent on August 14, 2006 and has found that the conditions of the petitioner's left thumb and lumbar spine, along with the restrictions related to those conditions, are causally related to his June 14, 2006 and August 14, 2006 work accidents, the arbitrator also finds that all physical restrictions imposed by the petitioner's treating physicians have been causally related to his work accidents as well. The Arbitrator finds no persuasive job offer of ligith duty by the Respondent at bar. Therefore, the petitioner is due temporary total disability benefits from August 15, 2006 through February 12, 2009.

In addition, the petitioner is due maintenance benefits, pursuant to Section 8(a), from February 13, 2009 through the date of Susan Entenberg's deposition, April 7, 2011. It was at this time Ms. Entenberg testified there was no stable labor market for petitioner. In this particular case(s) and set of facts, the Arbitrator adopts the testimony of Ms. Entenberg.

On February 12, 2009, the petitioner was returned to work with medium duty work restrictions. According to the testimony of vocational counselor Susan Entenberg, the petitioner is not able to return to his previous occupation as an ironworker within those restrictions. (PX 16 @ 9). It is found & adopted petitioner cannot return to work due to the conditions of his left thumb and lumbar spine, which were caused by his June 14, 2006 and August 14, 2006 work injuries. Any contrary testimony from a CRC from Genex was notably absent.

Following his release with permanent restrictions for his left thumb and lumbar spine, the petitioner began a job search in 2009. He met with Susan Entenberg on June 20, 2010 and after the meeting with Ms. Entenberg, the petitioner began recording his job search on paper. (PX 22).

While undergoing these vocational efforts, the petitioner was due maintenance benefits from the respondent. A petitioner is due maintenance benefits when their medical condition has stabilized, but they are still engaged in a prescribed vocational rehabilitation program. *Archer Daniels Midland Co. v. Industrial Commission*, 138 Ill.2d 107, 561 N.E.2d 623, 149 Ill.Dec. 253 (1990); *Connell v. Industrial Commission*, 170 Ill.App.3d 49, 523 N.E.2d 1265, 120 Ill.Dec. 354 (1st Dist. 1988).

From February 2009 through October 5, 2011, the petitioner performed a job search. He recorded 1079 employer contacts. During that time, the petitioner never received a single job offer from the nearly 280 employers who the petitioner marked on his logs as hiring. (Tr. 7/17/13 @ 47, 49-50; Tr. 7/15/14 @ 26-27; PX 22). On October 30, 2010, Ms. Entenberg had the opportunity to review the petitioner's job search logs. Based upon the unsuccessful but "very diligent" job search the petitioner had performed, Ms. Entenberg opined that there was no stable labor market available to the petitioner. (PX 16 @ 11-12). After reviewing updated job search logs from the petitioner through the date of her deposition, April 7, 2011, as well as reviewing the IME report from Dr. Bernstein, Ms. Entenberg's opinions regarding a stable labor market for the petitioner did not change. (PX 16 @ 12-14).

After reviewing the petitioner's job search logs, as contained in petitioner's Exhibit 22, the arbitrator finds that the petitioner's job search was diligent and reasonable. For the majority of the time that the petitioner was searching for employment, he was performing a self-directed search without any assistance from the respondent. The petitioner was diligent in findings positions within his restrictions. However, he was unsuccessful in obtaining any employment. Based upon these facts, the arbitrator finds that the petitioner is due maintenance benefits from February 13, 2009 through the date of Ms. Entenberg's deposition of April 7, 2011. It was at this time she testified no stable labor market existed for him. Even though he continued looking for work after that date, he did not find work.

After reviewing the petitioner's job search logs and the other evidence and testimony in this case, the arbitrator adopts the unrebutted opinion of Susan Entenberg and finds that no stable labor market exists for the petitioner as of April 7, 2011.

A claimant can satisfy his burden of proving he is not capable of obtaining gainful employment by showing either of the following:

1) that work was not available, in other words a diligent but unsuccessful attempt to find work; or
2) that based upon his age, experience, training, and education, he is unable to perform any but the most unproductive tasks for which no stable labor market exists.

Alano v. Industrial Commission, 282 Ill.App.3d 531, 534-5 (Ind. Comm. Div. 1996).

The petitioner in this case has satisfied his burden of proving he is not capable of obtaining gainful employment in both of the possible ways. He has performed a diligent, yet unsuccessful job search and, the unrebutted testimony of vocational counselor Susan Entenberg is that there is no stable labor market that exists for the petitioner.

Though the burden is on the employee to initially prove that his condition is such that he is unable to perform any services for which there is a reasonably stable market, once that burden is met, the burden then shifts to the employer to show that some kind of suitable work is regularly and continuously available.

Sterling Steel Casting Co. v. Industrial Commission, 74 Ill.2d 273, 384 N.E.2d 1328, 1329, 24 Ill.Dec. 163 (1979). Also see *Goldblatt Brothers, Inc* v. The *Industrial Commission*, the lengthy case from our Supreme Court on aggravation in causation plus the burdens of the parties. That treatise- like case involved a spinal injury.

Based on the totality of the evidence, the arbitrator finds a fact and a conclusion of law that the petitioner is permanently and totally disabled as of April 8, 2011, and hereby orders respondent to pay permanent total disability benefits of Respondent shall pay Petitioner permanent and total disability benefits of $1,032.20/week for life, commencing April 8, 2011, as provided in Section 8(f) of the Act.

Commencing on the second July 15th after the entry of this award, Petitioner may become eligible for cost-of-living adjustments, paid by the Rate Adjustment Fund, as provided in Section 8(g) of the Act.

IV. On the issue of whether penalties and attorneys' fees should be imposed upon respondent, (M), the arbitrator hereby finds:

The Respondent, through counsel during the hearing via cross examination and presentation of evidence, has met a baseline "good faith challenge" to the payment of compensation under *Avon* and *Brinkman*. This is so despite the totality of the testimony of Dr. Avi Bernstein.

#01 Arbitrator George J. Andros

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

Troy Jones,
Petitioner,

vs. NO: 12 WC 15541

Jernberg Ind.,
Respondent.

15IWCC0627

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 sole issue of nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 28, 2014, is hereby affirmed and adopted.

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

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

15IWCC0627

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $16,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 13 2015

David L. Gore

Mario Basurto

Stephen Mathis

o-08/06/15
dlg/wj
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JONES,TROY
Employee/Petitioner

Case# **12WC015541**

JERNBERG IND
Employer/Respondent

15IWCC0627

On 10/28/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

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

0532 HOLECEK & ASSOCIATES
JEFF GOLDBERG
161 N CLARK ST SUITE 800
CHICAGO, IL 60601

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

TROY JONES
Employee/Petitioner

Case #12 WC 15541

v.

JERNBERG IND.
Employer/Respondent

15IWCC0627

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on October 10, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On January 23, 2012, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $31,490.68; the average weekly wage was $605.59.
- At the time of injury, the petitioner was 44 years of age, married with three children under 18.
- The parties agreed that there are no unpaid bills for medical services.
- The parties agreed that the respondent paid $13,784.50 in temporary total disability benefits.

ORDER:

- The respondent shall pay the petitioner the sum of $363.35/week for a further period of 45.925 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 27.5% loss of the use of his right foot.
- The respondent shall pay the petitioner compensation that has accrued from January 23, 2012, through October 10, 2014, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Robert E. Williams

Signature of Arbitrator

October 28, 2014

Date

OCT 28 2014

FINDINGS OF FACTS:

On January 23, 2012, the petitioner, a shear and saw operator, fractured his right ankle after slipping and falling on ice. He received surgery at Mercy Hospital with Dr. Michael Maday for a 3 cm open wound over the medial malleolus, a deltoid ligament disruption, a comminuted, oblique fibular fracture and a small posterior tibia fracture. Dr. Maday performed an irrigation, debridement and open reduction and internal fixation of the right ankle fracture using screws and a 7-hole semi-tubular plate. The petitioner remained casted and on April 2nd, Dr. Maday removed the syndesmotic screw. The petitioner received physical therapy and work hardening. He was released to work on September 12th and returned to work on September 18th. On December 18, 2013, Dr. Maday noted that the petitioner's ankle was doing better but that he had difficulties with the cold. His findings were minimal swelling, full ROM, crepitation and a grossly intact neurovascular status. Further, the doctor noted that the petitioner may have some signs and symptoms of early degenerative changes. Anti-inflammatory medication and home exercises were recommended.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

There is no AMA impairment rating or evidence concerning the impact of the petitioner's injury in regard to his occupation, age or future earning capacity, as delineated in Section 8.1(b)(i) through (iv) of the Act, nor can any effect be inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of reduced range of motion, swelling and pain, morning stiffness and the need for Motrin every few days for pain and a compressive stocking for swelling. The records of Dr. Maday indicate that the

petitioner has crepitation and is developing early degenerative changes but do not corroborate his testimony of a reduced range of motion.

The respondent shall pay the petitioner the sum of $363.35/week for a further period of 45.925 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 27.5% loss of the use of his right foot.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
JEFFERSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Samuel Guithues,
Petitioner,

vs.

NO: 09 WC 01094
13 WC 31422
13 WC 35688

Gateway Regional Medical Center,
Respondent.

15IWCC0628

DECISION AND OPINION ON REVIEW

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

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

15IWCC0628

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 17 2015

David L. Gore

Mario Basurto

Stephen Mathis

o-08/06/15
dlg/wj
45

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

GUITHUES, SAMUEL
Employee/Petitioner

Case# **09WC001094**

13WC031422
13WC035688

GATEWAY REGIONAL MEDICAL CENTER
Employer/Respondent

15IWCC0628

On 1/29/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2412 BEATTY MOTIL & JONES
RONALD MOTIL
78 S MAIN ST PO BOX 730
GLEN CARBON, IL 62034

2027 WIEDNER & McAULIFFE LTD
KHRISTOPHER DUNARD
8000 MARYLAND AVE SUITE 600
CLAYTON, MO 63105

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)

Case # 09 WC 001094

Consolidated cases: 13 WC 031422 & 13 WC 035688

15IWCC0628

Samuel Guithues
Employee/Petitioner

v.

Gateway Regional 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 **Brandon Zanotti**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **June 10, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0628

FINDINGS

On the dates of accident, **March 23, 2008, July 3, 2013, and September 25, 2013**, Respondent *was* operating under and subject to the provisions of the Act.
On these dates: 3/23/08, 7/3/13 and 9/25/13, an employee-employer relationship ***did*** exist between Petitioner and Respondent.
On these dates: 3/23/08, 7/3/13 and 9/25/13, Petitioner ***did*** sustain an accident that arose out of and in the course of employment.
Timely notice of these accidents ***was*** given to Respondent.
Petitioner's current condition of ill-being ***is*** causally related to the 7/3/13 and 9/25/13 accidents.
In the year preceding the injury, Petitioner earned $**62,000.00**; the average weekly wage was $**1,085.20**.
On the dates of accident, Petitioner was **38 and 44** years of age, ***married*** with **2** dependent children.
Respondent ***has not*** paid all reasonable and necessary charges for all reasonable and necessary medical services.
Respondent shall be given a credit of $**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 for any medical bills it paid through its group medical plan for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $723.46 weeks for 14 weeks, commencing 3/5/14 through 6/10/14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, payable directly to the Petitioner of $1,455.00 for Granite City Emergency Physicians 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 between 3/23/08 – 3/24/09 and 7/3/13 to 6/10/14, 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 consistent with this opinion.

Respondent shall authorize and make payment for the medical treatment recommended by Dr. Naseer, including but not limited to lumbar MRI and a referral to a neurosurgeon for further evaluation of the lumbar spine, in accordance with Section 8(a) of the Act.

Petitioner's requests for penalties and fees is hereby denied.

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

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

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

Signature of Arbitrator

1.29.15
Date

ICArbDec19(b)

JAN 29 2015

15IWCC0628

BACKGROUND

Samuel Guithues ("Petitioner") filed three applications for adjustment of claim against his employer, Gateway Regional Medical Center ("Respondent"), seeking workers' compensation benefits. In the first application the claimant alleged that on 3/23/08, he injured his low back while moving a patient by hand and bending over. In the second application for adjustment of claim, he alleged that on 7/3/13, he aggravated his prior low back injury after moving a patient. In his third application, the claimant alleged that on 9/25/13 he aggravated his prior low back injury after being knocked down by a patient. All three cases were assigned to the Collinsville, Illinois docket in Madison County. Ax2, 3. The claims were consolidated and proceeded to an arbitration hearing on 6/10/14 in Mount Vernon, Illinois pursuant to Petitioner's Petition for Immediate Hearing under Section 19(b) of the Illinois Workers' Compensation Act ("the Act") (820 ILCS 305/1 *et seq.*) (West 2004) before former Arbitrator Brandon Zanotti. Ax1, Ax3. At issue were causal connection, liability for medical expenses, temporary total disability benefit, penalties and prospective medical treatment. Ax1, 3, 4. These matters were transferred to Arbitrator Bocanegra for review of all testimonial evidence and additional evidence submitted at trial. Arbitrator Bocanegra issued the decision that follows.

FINDINGS OF FACT

The following factual recitation is taken from the evidence presented at the arbitration hearing conducted on 6/10/14. Petitioner testified that he worked for Respondent as an occupational therapist since 2006. His duties included aiding patients to toilet, feed, bathe and dress themselves. In aiding patients to toilet or shower, he testified he used his arms to lift them. He also used his arms to lift patients out of bed, pull a patient onto a wheelchair or a potty chair. In addition, he testified he worked with orthopedic patients and in scheduling. Prior to 2006, he worked for Respondent as a clinical tech from 1994-2001.

On 3/23/08, while working for Respondent, Petitioner testified he sustained an accident and injured his low back while lifting a large patient from a bed to a wheelchair. He testified he felt pain shooting down his butt to his leg. That same day, Petitioner presented to Gateway Regional Medical Center and complaining of left lower back pain radiating into the left hip after helping lift a patient. Rx5:225-228. He testified that a couple of days later, his back "locked up." X-rays showed no evidence of acute post traumatic process. Petitioner attended physical therapy through-out the remainder of March 2008. Rx1:5.

On 4/14/08, Gateway noted Petitioner complained of increased pain with lifting, bending and walking. He complained of decreased sensation with bowel movement. An MRI was ordered. On 4/16/08, Petitioner underwent an MRI of the lumbar spine at the request of Dr. Knapp. Px2. The history listed noted back pain radiating to the bilateral buttocks and injury at work. Impression included small left paracentral disk bulge with annular tear at L5-S1 and moderate left neural foraminal stenosis secondary to disc bulge and focal facet hypertrophy.

On 4/29/08, Petitioner treated with Dr. Thomas Lee at the referral of Dr. Knapp. Dr. Lee's impression of the lumbar MRI was L5-S1 annular tear with protrusion. He recommended additional physical therapy and epidural injections.

On 5/7/08, Petitioner underwent a left S1 transforaminal epidural steroid injection. Rx1. On 5/20/08, Petitioner followed up and reported improvement following the first injection for the first several days but an eventual return of pain. On 5/21/08, Petitioner was assessed with chronic low back pain with history of ESI, adjustment disorder with depressed mood secondary to his injury. Petitioner was placed on Elavil.

On 6/2/08, Dr. Lee noted continuing complaints of left leg pain and a return of symptoms following lumbar injections. The doctor noted Petitioner felt as though he had worked up a tolerance to the beneficial effects of the TENS unit. Impression was left L5-S1 HNP and Petitioner elected to proceed with microdiscectomy. On 6/25/08, Dr. Lee performed and Petitioner underwent a left L5-S1 laminotomies with left L5-S1 discectomy for the diagnosis of left L5-S1 herniated nucleus pulpous with left L5 foraminal stenosis.

On 7/1/08, Petitioner began complaining of headaches, chills, nausea. Tests, including an MRI were ordered to rule out CSF leak. On 7/2/08, Petitioner underwent an MRI of the lumbar spine at the request of Dr. Lee. A small 3x2 cm fluid collection was identified in the spinous process. A CSF leak could not be excluded. It was noted that the prior left paracentral disk bulge seen on pre-operative MRI imaging was less prominent but that the moderate left neural foraminal stenosis from facet hypertrophy was still present. Rx5:236-237. A CT scan of the head was normal. According to Dr. Kitchens' report, Petitioner treated at St. Anthony for post-operative complications on 7/2/08 and 7/3/08. On 7/22/08, Dr. Lee saw Petitioner again and commented that Petitioner appeared to be undergoing postoperative problems, including some low back pain, occasional left gluteal pain, a suspected superficial vein clot and headaches, which resolved with a blood patch.

On 8/14/08, Dr. Lee noted that Petitioner's headaches had resolved and that he continued to present with low back pain. Petitioner was cleared to work light duty of lifting no more than 10 pounds. On 9/15/08, Petitioner followed up with Dr. Lee. Petitioner complained of ongoing occasional left gluteal pain, difficulty lifting his children, weakness with prolonged walking and that he was slowly advancing in therapies. Dr. Lee ordered work conditioning.

On 10/6/08, Gateway physical therapy progress note indicated Petitioner was ready to go back to work, that he was doing better with lifting when he can keep the weight close to his body, improved sitting tolerance in a supportive chair. Continued limitations were noted to be carrying weight away from his body and prolonged stooping. Range of motion was full at the trunk, limited with side bending and rotation by 50% and extension by 50%. Rx5:238. On 10/7/08, Dr. Lee authored a letter to Respondent's insurance carrier, Gallagher Bassett Services, Inc. regarding Petitioner. Rx6:427. The doctor described Petitioner's current condition at that time as mostly pain free with left sacral pain, trouble with stooping, getting in and out of cars, flexion at 30 degrees with sacral pain, extension at 20 degrees without pain and lumbar

weakness. *Id.* Petitioner was allowed to return to work without restriction and was placed at maximum medical improvement. *Id.*

On cross examination, Petitioner acknowledged that on his final physical therapy note, it was noted he could frequently lift and carry up to 50 pounds, could carry a crate of 50 or more pounds up to 100 feet and was able to push a cart of 320 pounds for greater than 100 feet. He further acknowledged that these tasks were consistent with his job requirements and that is why he was eventually able to return to work without restrictions. Petitioner said he was able to work full duty with the aid of more and more pain medications. He testified that at the time he was released, he still had pain going down the low back and into the legs. He testified he requested to see Dr. Lee again via his work comp liaison, Mr. Barb Autocanas, but never received a response.

2009

Petitioner testified that he returned to treatment sometime in 2009 following what was described as a flare up of low back pain and symptoms.

On 2/2/09, Petitioner presented to Gateway Medical Center where it was noted that Petitioner's symptoms seemed to worsen toward the end of December 2008. Admitting diagnosis was sciatica and low back pain. Rx5:241. Complaints consisted of left lower back pain radiating into the left leg to the knee. Level of function was noted to be limited to walking 30 minutes and difficulty at work with sit-to-stand and stand-to-sit patient transfers. Petitioner expressed difficulty with stairs, grocery shopping, kneeling, squatting, sleeping and playing with his kids. Petitioner recalled an incident in January where he tried playing with his children and experienced increased pain. Petitioner was unsure whether his flare up was due to picking up his sons or working with heavy patients at work. Rx5:244. Physical therapy was recommended and approved by Dr. Harmon. On 2/13/09, Petitioner left a message with his doctors that he thought he had "overdid it" regarding his low back.

On 3/9/09, Gateway issued a physical therapy progress report. Petitioner reported 80% improvement in functionality since his flare up of symptoms in December 2008. Pain remained intermittent in the lower back, left hip and buttock. Fabere and straight leg raise testing were positive and slump test was slightly positive on the left. Therapies were discontinued. The medical records show that Petitioner did not treat the remainder of 2009 for any lower back conditions, issues, flare ups or problems. Petitioner returned to work without any restrictions.

2010

According to the evidence submitted at arbitration, the next medical record in which Petitioner treats for his low back was nearly 14 months later on 5/20/10. At that time, Petitioner was seen by Dr. Brian Forbes, a chiropractor out of Granite City, Illinois. At that time, Petitioner related his 2008 work accident and that he had been back to work with an increase in symptoms. Petitioner related not being able to perform normal work activities at that time because of pain and weakness. Dr. Forbes noted that since the [2008] accident Petitioner had problems with

"bathing, dress, standing, leaning, walking, stopping, squatting, climbing, bending, twisting, carrying, lifting, pushing, pulling, sitting, driving, riding in vehicles, exercising, loss of sexual drive, sleeping and toileting." The doctor noted that Petitioner described pain on a "daily basis," that taking Hydrocodone that sometimes did not help and load bearing increased pain. Physical exam showed tenderness to palpation and trigger points were identified in the low back, left glute, left quad, left sacroiliac and left piriformis. Range of motion was reduced. The doctor diagnosed post-laminectomy syndrome, degeneration and displacement of lumbar disc without myelopathy, spinal stenosis, myalgia, myositis, and mononeuritis of the lower limb and late effects of accidental fall. Ongoing treatment with Dr. Forbes included therapies, stretching, hot and cold packs, electrical muscle stimulation, spinal adjustment and ultrasound.

On 8/16/10, Petitioner once again treated with Dr. Forbes, who documented Petitioner's unknown exacerbation as occurring "from time to time." Petitioner noted some improvement but ongoing pain in the low back and left buttock. On 8/18/10, Petitioner underwent an MRI. Px2. Impression was moderate left paracentral and lateral disk bulging at L5-S1 level giving moderate to severe left neural foraminal stenosis, right neural foraminal stenosis secondary to facet hypertrophy, moderate right neural foraminal stenosis at L4-5 secondary to right-sided facet hypertrophy and post-operative changes of the lower spine. Petitioner continued to treat with Dr. Forbes through the end of 2010. Px2. He testified he believed that as treatment progressed, it was slowly no longer helping him as it had in the beginning.

2011

On 1/19/11, Petitioner treated with his PCP, Dr. Harmon. Rx2:17. The doctor noted back pain, persistent back discomfort. He read the MRI as showing some foraminal stenosis and paracentral disc bulging.

Petitioner's treatment with Dr. Forbes continued in January, February, March, April, May, June and July of 2011. Px2. On 8/4/11, Petitioner saw Dr. Forbes, who noted low back pain, left buttock pain, right buttock pain, left calf pain, left heel pain, right calf pain and some neck pain. Diagnosis was unchanged and that doctor noted that treatment goals included not working in pain.

On 8/16/11, Petitioner underwent a Section 12 exam with Dr. Daniel Kitchens at the request of Respondent. Rx1. Petitioner's current complaints included low back pain into the left buttock, into the mid thigh, pain on a daily basis and gradual worsening pain over the last few months, requiring the use of increased medications. Petitioner reported taking medications without relief. Petitioner related that the "pain he is having now is no way comparable to the pain he had prior to surgery." At that time, Petitioner reported no additional incident or traumatic event at work since his work injury in 2008. Relevant review of symptoms was significant for back, hip, leg, knee and ankle pain, decreased bladder control. The doctor noted Petitioner's occupational concern included lifting up to 50 pounds and stress. Physical exam showed 5/5 strength through out, good range of motion of the lumbar spine, no pain to palpation of the lumbar spine, negative straight leg raise and normal tandem gait.

Dr. Kitchens reviewed medical documentation noting an MRI in 2008 as showing a left sided L5-S1 annular tear with protrusion, a subsequent left S1 transforaminal ESI on 5/7/08 with a return of left sided buttock pain. He also reviewed a series of medical notes but noted he had no MRI films or report for review. The doctor opined that Petitioner suffered from degenerative disc disease without evidence of recurrent disc herniation or radiculopathy, that his current condition of ill being was not causally related to the initial work injury in part based upon a release to full duty work and "blank" medical records until May 2010. The doctor concluded Petitioner was not in need of any additional medical care related to his back. Rx1:11.

Following the IME, on 9/15/11 Petitioner returned to Dr. Forbes. Symptoms and complaints were essentially unchanged from the prior visit. Px2. The doctor found hypotonicity of the lumbar musculature unchanged, mild tenderness to palpation over the lumbar and sacroiliac region, improved range of motion with pain at the end and subluxations at lumbar and pelvis regions. Diagnosis was unchanged. Treatment goal included, in part, "not hurt while he is at work without pain within 8 weeks."

On 11/11/11, Petitioner treated with Dr. Forbes for the last time. Petitioner commented that he had been trying to "get by" without coming to see Dr. Forbes and that he was still depressed that the "littlest thing can cause him marked pain." Petitioner denied any improvement in bowel, low back, and heaviness in the leg or in radiating pain. Diagnosis remained unchanged. The doctor continued to recommend a course of care whereby working in pain would be reduced or gone. Dr. Forbes commented that Petitioner will have residual problems with expectations of exacerbations. The doctor recommended further testing to rule out bowel symptom being of neuro origin or a side effect of medication. Petitioner was directed to return as needed.

Dr. Forbes testified that he diagnosed Petitioner with post-laminectomy syndrome, degeneration of the lumbosacral disc, displacement of the lumbar disc without myelopathy, mononeuritis of the lower limb, and spinal stenosis of the lumbar region, myalgia and late effects of the fall or trauma. The doctor opined, to a reasonable degree of chiropractic certainty, that the injuries Petitioner sustained while helping the patient at Respondent's place of employment were related to Petitioner's multiple diagnoses. He further stated that Petitioner's current condition could easily be related to the accident and/or the treatment of surgery afterward. On cross examination, the doctor admitted that when he made his initial diagnosis and initial causation opinion, he did not have any imaging studies or prior medical records. The doctor described the care he gave Petitioner as palliative in nature and opined that Petitioner would continue to have periods of exacerbation and remissions, that those exacerbations will become worse because of the degenerative nature of future tears within the injured area.

Petitioner testified he continued to work through-out 2010 and 2011 in pain while treating with Dr. Forbes and also maintained another job at Rosewood nursing home working weekends doing evaluations. That employment eventually ended.

15IWCC0628

2012

Although the evidence shows Petitioner continued to see Dr. Harmon throughout the first part of 2012, the next medical record showing treatment related to the back with Dr. Harmon was on 7/18/12. Rx5, 7. The doctor noted persistent lower back pain with radicular component on the left. On 7/23/12, a new MRI of lumbar spine was obtained and compared to the prior 2010 MRI. Mild disc dehydration at L5-S1 and L2-3 and mild loss of disc height at L5-S1 without significant change were noted. At L5-S1, left paracentral to neural foraminal broad-based disc protrusion superimposed on disc bulge and moderate bilateral facet hypertrophy showed no substantial change. Resultant mild to moderate right and severe left neural foraminal stenosis showed no substantial interval change. No canal stenosis was noted. At L4-5, mild concentric disc bulge and moderate bilateral facet hypertrophy and resultant moderate right and mild left neural foraminal stenosis showed no substantial interval change. No canal stenosis at this level was noted. Final impression was no substantial interval change. Rx5:356-7, Cf. Rx5:334-5.

Following the July 2012 MRI, medical and testimonial evidence showed that Petitioner next treated for his back nearly three months later on 11/20/12. Px1, T.29. Petitioner had been referred by Dr. Harmon to Dr. Riaz Naseer, a board certified neurologist. Dr. Naseer testified that it was the first time he had seen Petitioner and that he complained of persistent low back pain ongoing for several years since 2008, radiating to the back, left calf, left foot and left thigh. Physical exam showed gait compensation, limping and pain and tenderness to the lower spine. The doctor prescribed pain medications at that time and recommended a new MRI.

2013

Two months later, on 1/18/13, Dr. Naseer saw Petitioner again and noted moderately severe, persistent lower back and leg pain. Petitioner still had radiating pain into the left calf as well as the right calf, left foot, right foot, left thigh, right thigh with stabbing and throbbing pain. Four months later, Dr. Naseer saw Petitioner on 4/26/13. The doctor testified that he noted Petitioner's low back pain was worsening with pain radiating into the back, left calf, right calf, left foot, right foot and left thigh, right thigh.

On 6/20/13, Dr. Harmon's office noted Petitioner's phone call regarding loss of control of urine. Petitioner related it had occurred twice in the past and he was worried it is because of his low back problems. The doctor recommended a repeat MRI with contrast.

Petitioner testified that on 7/3/13, while working for Respondent, he injured his low back when he transferred a patient from a wheelchair to a potty chair. He testified the injury increased his symptoms. He presented to Gateway Medical that same date. Rx5:409-412, Rx7:450. Complaints included severe low back pain and radiation in to the left buttock. The attending physician noted that Petitioner was taking the following medications at that time: Vicodin, Wellbutrin, Cymbalta, Soma, Lisinopril, Oxycontin, Trazadone, Advair, Albuterol and Lidoderm patch. Neurologic exam showed no motor or sensory deficits. Clinical impression was acute lumbar myofascial strain and chronic low back pain. The attending physician ordered Dilaudid, Toradol, Valium and Zofran. Rx7:452. Petitioner was discharged and referred to Dr. Harmon.

Rx7:449. He testified he was able to continue working with stronger medications and a cane, prescribed by Dr. Harmon.

On 7/10/13, Petitioner followed up with Dr. Naseer; at which time he recommended Petitioner remain off of work. Px1. Dr. Naseer opined that the 7/3/13 work incident aggravated Petitioner's preexisting lumbar conditions. Px1:12. On 7/26/13, Petitioner saw Dr. Naseer. The doctor noted radiating pain worse down left lower extremity.

On 8/7/13, Dr. Naseer's office took down a message from Petitioner informing them that his leg had gone numb while watching a movie and that his pain was bad that day. Later that same month, on 8/21/13, Petitioner left another message to his doctor informing him that his pain was radiating into the legs.

Petitioner testified that on 9/25/13, while working for Respondent and answering a call light, a patient knocked him on his back. He testified it increased his low back pain. He testified that there is always burning in both legs, across the back, that sometimes he loses bladder control.

Dr. Naseer next saw Petitioner 10/11/13 and noted that his condition was unchanged. Dr. Naseer testified that on 9/25/13 Petitioner said he was kicked in the chest by a patient while at work and fell to the floor, re-injuring his back. At his deposition, the doctor opined that he believed the 9/25/13 was an aggravation of Petitioner's preexisting symptoms. The doctor again saw Petitioner 11/20/13 and on 12/11/13. He testified that Petitioner's symptoms were unchanged. At that time, he referred Petitioner to Dr. Kennedy, a neurosurgeon based upon his review of Petitioner's MRIs and his overall condition, which was not improving and was only being treated with pain medications. Dr. Naseer testified that he continues to recommend Petitioner remain off of work and that Petitioner be evaluated by Dr. Kennedy.

2014

On 2/25/14, Petitioner presented a second IME with Dr. Kitchens. Rx2. At that time, Petitioner related his two additional injuries allegedly occurring July 2013 while transferring a patient and again September 2013 when he was knocked down. Petitioner's complaints at that time included: use of a cane to ambulate, diminished activity, ability to walk only 5 minutes before having to sit or lie down, worsening pain with prolonged sitting, constant sharp needle, burning-type pain into the lower back into bilateral hips and partial left leg, along with loss of bladder/bowel control. Further, Petitioner related that he was unable to sit or stand, play with his children or go to a movie without discomfort. Petitioner's symptoms had worsened following the 2013 incidents at work and he had last worked 10/10/13. Neurologic exam at that time showed antalgic gait from sit to stand, pain with upper extremity strength testing, no pain with lower extremity strength testing, sensory exam was normal and straight leg raise was negative. The patient information sheet contained a drawing depicting Petitioner's pain as located in the low back and down the left leg just above the knee rated 8/10 described as a burning sensation. After reviewing various medical records, the doctor concluded that Petitioner's subjective complaints of severe low back pain were without any objective signs of radiculopathy. He

opined that Petitioner's "back pain preceded the alleged work incidents of July 3, 2013 and September 25, 2013, and he required narcotic pain medication well before these two work incidents. I do not find any objective basis for his report of subjective severe lower back pain." Rx2:21. The doctor further concluded that Petitioner's ongoing use of narcotic medications was not related to his subsequent work accidents, that Petitioner's subjective complaints were not objectively verifiable but that conservative treatment measures to date had been reasonable but not related to the subsequent work accidents, that Petitioner was not in need of further medical treatment and that he had otherwise reached maximum medical improvement.

On that same day, Dr. Kitchens drafted an addendum report at the request of Respondent's 3/17/14 letter. Rx3:28. After reviewing medical records from Dr. Forbes, DC, along with his evidence deposition, Dr. Kitchens concluded that his opinions had not changed. He testified he did not believe any of Dr. Forbes' chiropractic treatment to be reasonable or necessary as Dr. Forbes did "not provide any treatment for the disc herniation to the left side at L5-S1."

On 4/16/14, Dr. Kitchens, testified via evidence deposition before counsel for both parties. Rx4:34-96. It was the doctor's opinion that Petitioner's current low back pain was not related to his March 2008 injury based on a July 2008 MRI showing no recurrent or residual disc herniation and based on a full duty release by Dr. Lee in October 2008. Dr. Kitchens also believed subsequent MRIs only showed degenerative changes unrelated to any work injuries. The doctor diagnosed Petitioner with worsening lower back pain without radiculopathy.

On cross examination, Dr. Kitchens acknowledged he had met with Petitioner on only two occasions. In addition, the doctor agreed that it would not be unusual in certain patients to have intermittent discomfort in the back following a surgery. The doctor also agreed that at his evaluation of Petitioner, his symptoms included pain increased with walking, discomfort of the low back, radiation of pain into the right glute, decreased sensation with bowel movement. When asked about his diagnosis of degenerative disc disease, Dr. Kitchens agreed that such conditions could be aggravated by being knocked to the ground or if the back is jerked trying to help a patient. Rx4:76. The doctor opined that despite his diagnosis of chronic lower back pain, Petitioner was not in need of any additional medical treatment as it related to his two most recent work accidents.

Petitioner testified temporary total disability benefits stopped 3/4/14. He also testified he had not been back to work since being ordered home by Respondent. Petitioner stated that if he were offered vocational retraining and/or additional treatment he would accept it. He related that his current low back problems include difficulty sleeping, standing and sitting for a long time and a constant burning sensation down both legs and across the low back. He testified he feels better in the mornings than at night, has bladder control issues and has experienced his left leg giving way. He explained he cannot walk more than 30-50 feet without feeling an increase in low back pain and an increase in burning pain down both legs. He also testified that he cannot bend, lift or stoop without an increase in pain and has his children help him dress. He cannot sit in church for very long or drive for very long. Currently, he takes Oxycontin, Soma and pain

patches for pain relief. He testified that his pain never goes away, just the intensity changes and that since his first accident in March 2008, his back pain has never gone away.

CONCLUSIONS OF LAW

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

It is undisputed that Petitioner suffered accidents occurring on 3/23/08, 7/3/13 and 9/25/13 arising out of and in the course of his employment with Respondent. Ax1. The parties' dispute is over whether Petitioner's low back condition(s) have fully resolved and if not, whether his current condition of ill-being is causally related to one, some or all of the work accidents. The Arbitrator concludes that Petitioner has proven by a preponderance of credible evidence that his current condition of ill-being is causally related to his work accidents occurring on 7/3/13 and 9/25/13, as more fully set forth below.

The evidence shows Petitioner sustained a herniated nucleus pulposus of the left L5-S1 as a result of his 3/23/08 work accident, which eventually necessitated a left L5-S1 microdiscectomy performed by Dr. Lee on 6/25/08. He subsequently underwent usual post-operative rehabilitation, which was temporarily complicated by a small fluid collection for which he was treated and released. Petitioner was released to full duty work on 10/7/08. Petitioner testified that almost immediately upon his return to work full duty, he began experiencing low back and lower leg pain. His unrebutted testimony was that following his October 2008 release, he attempted to get back into Dr. Lee but Barb Autocanas, work comp liaison, was unable to get a return visit approved. He credibly admitted to his doctors in February 2009 that he was not sure if his increasing back pains in December 2008 and January 2009 were accidents or merely flare ups of his low back pain stemming from his prior work injury. He gave examples of lifting his kids and lifting patients at work. Petitioner also contacted his physical therapists to notify them of increasing pain and "over doing it." The Arbitrator finds Petitioner's timely and consistent complaints of pain and his efforts to get treatment during this time credible.

Treatment records show Petitioner treated with Gateway for physical therapy until 3/24/09, at which time Petitioner reported 80% improvement since experiencing increase in low back and leg symptoms. Petitioner was released physical therapy and Dr. Harmon did not order or approve additional therapies. Petitioner continued to work full time and in an otherwise full duty capacity. The Arbitrator concludes that Petitioner's 3/23/08 accident resulted in a herniated nucleus pulposus at L5-S1 requiring and necessitating Petitioner's 6/25/08 back surgery. The Arbitrator further concludes that although Petitioner was released to return to work on 10/6/08, Petitioner's pain did not subside, prompting him to timely return to treatment. Based on the medical evidence and testimony, the Arbitrator concludes that Petitioner's condition of ill-being, as it existed between 3/23/08 and 3/24/09 is causally related to his 3/23/08 work accident having stabilized on 3/24/09, at which time he was released from medical care.

After 3/24/09, Petitioner did not seek or return to any medical treatment for his low back or lower extremities for nearly 14 months, until 5/20/09, at which time Petitioner began treatment with Dr. Brian Forbes, DC. No reason or explanation was given for this 14 month gap in treatment. There was testimony suggesting Petitioner treated with his PCP and the VA during this period but no corroborating records were introduced showing that Petitioner treated during this 14 month gap. In addition, there was no testimony or evidence that Petitioner contacted Barb Autocanas, work comp liaison, as he had in the past, to re-enter treatment at any time during these 14 months. When Petitioner did finally re-enter treatment with Dr. Forbes, the doctor admitted that his care was nothing more than palliative in nature and concluded that Petitioner should expect to have residual problems or bouts of exacerbations.

Further complicating the record, Petitioner testified he continued to obtain pain medications for his back after being released by Gateway in March 2009. However, no records support Petitioner's testimony. There are records in June 2011 and July 2011 whereby Dr. Harmon mentions "chronic" back pain and medications but does not treat or prescribe anything in that regard. See, Rx5:359-60, 373-74. Petitioner also testified that he had visited the VA for pain medications for his back. For whatever reason, however, those records were not placed into evidence. In addition, medical records with Dr. Harmon from 2008 through 2011 are for conditions wholly unrelated to the back and for which there is no mention of back pain other than what was mentioned previously.

Following the release by Dr. Forbes, another 8 months passed until the next treatment record related to the back in July 2012 appears. At that time, MRIs are compared showing no substantial interval change. After July 2012, nearly another 4 months pass, at which time Dr. Naseer testified he first saw Petitioner on 11/20/12. However, Dr. Naseer's testimony that he first treated Petitioner on 11/20/12 is at odds with a neurology consultation note dated 5/16/11, when Dr. Naseer sees Petitioner for severe headaches, at which time there is no mention of back pain. Rx5:375-376.

The Commission has previously denied benefits based upon a lack of causal connection when there is a significant delay in receiving treatment or a significant gap in receiving treatment. *Gonzalez v. J. F. Daley Int'l,* 94 WC 23862, 99 IIC 3121 (causal connection denied based upon claimant's delay in seeking treatment for 16 days.); *Bauer v. E M Wiegman,* 98 WC 39838, 02 IIC 0839 (causal connection denied based upon an 8-month delay in seeking treatment); *Mercado v. Trak Auto,* 99 WC 61550, 02 IIC 0412 (causal connection denied in part based upon more than a year of a gap in treatment). Based upon the foregoing, the Arbitrator is unable to causally connect Petitioner's condition of ill-being as it existed between 3/35/09 – 7/2/13 back to his 3/23/08 work accident.

However, the Arbitrator does find that Petitioner has proven that his current condition of ill-being is causally connected to his two subsequent work accidents occurring on 7/3/13 and 9/25/13. On those dates, the evidence shows Petitioner re-injured his low back while working with patients at Respondent's place of employment. He timely reported these accidents and promptly sought treatment. Dr. Naseer testified he believed Petitioner suffered aggravations to his pre-existing low back issues as a result of these two work accidents. Because Petitioner's

worsening back condition was aggravated by the two work accidents, Dr. Naseer testified Petitioner was in need of an MRI and a consultation with a neurosurgeon. Dr. Kitchens, on the other hand, did not believe Petitioner sustained any injury from these two subsequent injuries, as Petitioner had been taking pain medications prior to the two work accidents and based upon his reading that the prior MRIs showed no substantial interval change. The Arbitrator must respectfully disagree with Dr. Kitchens. Contrary to Dr. Kitchens' assertion that Petitioner had been taking pain medications for his back prior to the two new work accidents, there was no evidence submitted that Petitioner had been taking pain medications for back pain. The record instead suggests Petitioner had been taking medications for unrelated headaches and occipital issues and that there was a significant gap in treatment. Even if Petitioner had been taking medications to cope with back pain, Petitioner testified he experienced a significant increase his back symptoms following the two recent work accidents. That testimony, in the opinion of the Arbitrator, is supported by the 7/3/13 emergency room record when the attending physician ordered Dilaudid, Toradol, Valium and Zofran for Petitioner's complaints. Petitioner also placed several calls to Dr. Naseer informing his office of worsening back pain and lower leg symptoms. Following the second injury on 9/25/13, Petitioner testified he once again experienced an increase in symptoms. Dr. Naseer was prompted to order an MRI and ordered a referral to Dr. Kennedy. Dr. Kitchens also testified that because there was no substantial change between MRIs, he did not believe Petitioner's current condition to be related to his work accidents. However, Dr. Kitchens ignored the fact that the MRIs on which his opinions are based pre-date the two recent work accidents. In addition to worsening and increasing symptoms, the fact that the MRIs pre-date his two recent work accidents is the reason Petitioner's current treating physicians have recommended a new MRI. The Arbitrator adopts the medical opinions and conclusions of Petitioner's treating physicians in this regard over those of Dr. Kitchens.

Based upon the medical record and testimony, the Arbitrator finds that Petitioner's current condition of ill-being is causally related and connected to his 7/3/13 and 9/25/13 work accidents.

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?

The Arbitrator has concluded that Petitioner's condition of ill-being as it relates to the 3/23/08 accident stabilized and that Petitioner reached maximum medical improvement for this accident on 3/24/09. During this time, the evidence shows Petitioner suffered a complication to the spine following surgery and treatment was rendered to rule out a CSF leak. Petitioner submitted evidence suggesting that medical bills related to treatment for the infection had not been paid. However, the Arbitrator declines to award those bills as there are no corresponding or corroborating medical records in evidence showing treatment for this infection with the facilities showing outstanding balances due. The only medical record showing post operative treatment for a possible spinal infection is dated 7/1/08 and appears in medical records for Gateway. Rx5:232-234. Therefore, the Arbitrator declines to award medical bills for St. Anthony's Medical Center and Pathology Associates.

Regarding the medical bills from Dr. Forbes, because Petitioner's condition stabilized as of 3/24/09 as it relates to his first work accident, the Arbitrator declines to award medical bills for Dr. Brian Forbes as there is no causal connection between Petitioner's condition at that time to the 3/23/08 accident. In addition, Petitioner testified that after some time, the treatment with Dr. Forbes was no longer helpful and Dr. Kitchens found it to be unrelated to the first accident due to the large gap in treatment.

Petitioner submitted for consideration repayment of Blue Cross Blue Shield's subrogation for payments made in the amount of $5,649.46. Ax1, Px5. Respondent shall be given a credit for medical benefits that have been paid between 3/23/08 – 3/24/09 and 7/3/13 to 6/10/14, 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 consistent with this opinion.

Petitioner submitted a bill for payment from Granite City Emergency Physicians for date of service 7/3/13. Ax1, Px5. Having found Petitioner's current condition of ill-being is related to Petitioner's subsequent two work accidents, the Arbitrator finds that Respondent has not yet paid all appropriate charges for all reasonable and necessary medical services rendered during these period. Respondent is ordered to pay the unpaid medical bill for Granite City Emergency Physicians, subject to the applicable fee schedule as outlined in Sections 8.2 and 8.2(e) of the Act.

The Arbitrator declines to award Petitioner reimbursement for out of pocket expenses in connection with prescription medications claimed. Px5. There is no evidence that any of his treating doctors prescribed Lorazepam, Citalopram, Hydrocodone, Ibuprofen or Propoxyphene-N for any condition(s) related to Petitioner's lumbar spine as a result of these work accidents.

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

Having found Petitioner's current condition of ill-being related to his most recent two work accidents of 7/3/13 and 9/25/13, the Arbitrator concludes that Petitioner is in need of and entitled to prospective medical care. The evidence shows that Petitioner sustained two new work accidents, aggravating his pre-existing low back condition. Dr. Naseer opined that following his two work accidents, which increased his symptoms significantly, Petitioner would benefit from a new MRI and a consultation with Dr. Kennedy to see what further treatment, if any, is indicated. The Arbitrator finds these recommendations for prospective care related to his work accidents and orders Respondent to pay for and authorize the MRI of the lumbar spine and consult visit with Dr. Kennedy. The Arbitrator declines to award any vocational rehabilitation at this time as there is no doctor recommending any such course of care and it is premature since Petitioner is in need of further care.

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

The Arbitrator concludes that Petitioner is entitled to temporary total disability benefits from 3/5/14 up to and including 6/10/14. This is based on the evidence the medical opinion of

Dr. Naseer that Petitioner's most recent work accidents resulted in an aggravation of his preexisting back conditions and has resulted in Petitioner being unable to return to work in a full duty capacity. Dr. Naseer also testified that Petitioner's condition has not yet stabilized and that he is in fact in need of further medical care. Therefore, Petitioner is awarded and Respondent shall pay TTD benefits of $723.46 for 14 weeks commencing 3/5/14 up to and including 6/10/14 as provided in Section 8(b) of the Act.

Issue (M): Should penalties or fees be imposed upon Respondent?

The Arbitrator declines to impose penalties or fees upon Respondent. Petitioner contends that Respondent did not have a valid basis to suspend TTD in March 2014. However, Respondent submitted an addendum by Dr. Kitchens into evidence dated February 2014 wherein the doctor continued to opine that Petitioner's condition was unrelated to his work accidents. The Arbitrator does not see Respondent's reliance on this opinion to be unreasonable, vexatious or for delay. Respondent paid Petitioner benefits following his two most recent work accidents until it received new opinions from Dr. Kitchens. Although Dr. Kitchens acknowledged Petitioner's subjective complaints, he did not agree that they were related to any work injury, which in the Arbitrator's view, is not an unreasonable basis for Respondent to dispute Petitioner's claims. Although the Arbitrator ultimately disagrees with the opinions of Dr. Kitchens in this matter, it cannot be said that Respondent's conduct in this regard is so unreasonable as to warrant penalties or fees. Therefore, Petitioner's petition for penalties and fees is denied.

Signature of Arbitrator

1.29.15
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dewayne Walker,

Petitioner,

vs. NO: 11WC 37638

Illinois Medi-Car, Inc.,

15IWCC0629

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 temporary total disability, penalties, vocational rehabilitation, maintenance, temporary 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. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

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

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,700.00. 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.

DATED: AUG 17 2015
o061615
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

DISSENT

I respectfully dissent from the majority decision and would reverse the Arbitrator as to his not awarding vocational rehabilitation and maintenance. The Arbitrator awarded 92 and 2/7 weeks of temporary total disability benefits and $6,442.64 in medical expenses to Petitioner. Those awards should not be disturbed.

Petitioner was employed by Respondent as a Medi-Car transport driver who also assisted with lifting customers in and out of the company vehicles when needed. On August 25, 2011, Petitioner injured his back while assisting a customer into his home. Subsequently, Petitioner underwent a L5-S1 fusion surgery on March 6, 2012, and then a revision surgery eight months later. He worked in a light-duty status from March 17, 2013 until April 22, 2013 when he was then taken off of work by his physician. Petitioner was then found to be at maximum medical improvement ("MMI") on July 8, 2013, and allowed to return to work with permanent restrictions. He did clerical work (a light-duty accommodation) for the Respondent until early August 2013 when he was offered the position of IMC Porter, which in fact was not light duty, but instead over and above his restrictions. According to Respondent there were no other positions available that could accommodate Petitioner's restrictions. After August 9, 2013 he was no longer employed by Respondent because he did not accept the Porter position.

There was never any testimony or a medical opinion proffered by any party to insinuate that the Petitioner was somehow faking his pain and capabilities, nor was there an accusation of malingering.

The Porter position was not a valid job offer within Petitioner's permanent restrictions; thus, he should be entitled to vocational rehabilitation and maintenance benefits for the period of August 9, 2013 (his last day of work with Respondent) to May 12, 2014 (the first trial date). The

Human Resources Manager ("Manager") testified on March 10, 2014 regarding the Porter position and Petitioner's restrictions: "I believe he was not able to lift more than 30 pounds. He couldn't be on his feet for extended period of time." " Primary responsibility would be to wash and clean the inside and outside of the ambulance, and also to make sure it was stocked with supplies." [sic] The Manager further went on to testify that the porters worked an eight-hour shift, in teams of two, received two fifteen-minute breaks and a lunch break, and that they "probably wash anywhere from 15-20 ambulances throughout their shift." He also testified that it takes "about approximately 15 to 30 minutes" to wash one ambulance. The manager agreed during testimony that a porter would be squatting, bending, crouching, and stooping for over two and a half hours per day. Porters are expected to clean the garage when they do not have an ambulance to wash, but can also sit down when they have completed all the tasks as outlined.

Additionally, Respondent undertook an independent medical exam for Petitioner, and that physician opined on May 16, 2013 that "It is reasonable for him to work at a sedentary demand level." Per Petitioner's physician on July 8, 2013 when Petitioner was found to be at MMI, Petitioner could "return to work with permanent restrictions per his last work conditioning note dated 6/30/13 functioning at the light to medium physical demand level." Then, in a letter dated February 19, 2014, Petitioner's physician stated that he would "defer to the FCE (functional capacity evaluation) in order to delineate Mr. Walker's capabilities" in response to Petitioner's request to clarify Petitioner's restrictions. The FCE report by ATI physical therapy dated June 6, 2013, notes that Petitioner "demonstrated functional capabilities which meet the LIGHT Physical Demand Level." The FCE report also shows that in an eight hour work day, Petitioner has the capability to stand for four hours (no longer than thirty minutes at one time), and to walk for four to five hours. Moreover, he can bend/ stoop, crouch, and squat "occasionally" (thirty minutes to two hours and thirty minutes). As noted above, the Manager agreed that the Porter position would require the employee to bend, stoop, crouch, and squat for over two hours and thirty minutes per day. Further, the IMC Porter job description also provides a basis for determining that it was beyond Petitioner's physical limitations. A Porter, "Must have good physical mobility to bend, lift, and reach," and is "frequently required to stand, bend, and walk" because they are washing the inside and outside of the vehicles. Further, considering that a Porter would spend three hours and forty-five minutes of the work day to wash just the minimum amount of ambulances in the minimum amount of time, it is likely that a Porter would exceed four hours standing while working almost every work day. This is especially true given that the Porters are also required to sweep the garage at a minimum of once per work day. Therefore, the Porter position exceeds Petitioner's work restrictions and cannot be considered a valid job offer.

For the aforementioned reasons, I would award this Petitioner vocational rehabilitation and maintenance for the requested time period in addition to the temporary total disability and medical expenses that were awarded.

Thomas J. Tyrrell

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

WALKER, DEWAYNE
Employee/Petitioner

Case# **11WC037638**

ILLINOIS MEDI-CAR INC
Employer/Respondent

15IWCC0629

On 7/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0290 KARCHMAR & STONE
LARRY KARCHMAR ESQ
111 W WASHINGTON ST SUITE 1030
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
BRIAN RUDD
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

15IWCC0629

STATE OF ILLINOIS)
)SS.
COUNTY OF DuPage)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Dewayne Walker
Employee/Petitioner

v.

Illinois Medi-Car, Inc.
Employer/Respondent

Case # 11 WC 37638

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Wheaton on 2/14/2014, in Chicago on 3/10/2014, and in Wheaton on 5/12/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☐ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
K. ☐ 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 **Vocational Rehabilitation**

FINDINGS

On the date of accident, **8/25/2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**24,606.40**; the average weekly wage was $**473.20**.

On the date of accident, Petitioner was **46** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**31,250.36** for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $**31,250.36**.

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

ORDER

Pursuant to Section 8(a) of the Act, the respondent shall pay the claimant $6,442.64 in medical expenses, subject to the limits of the Section 8.2 fee schedule, as set forth in the attached decision.

Pursuant to Section 8(b) of the Act, the respondent shall pay the claimant 92 & 2/7 weeks of TTD at $319.00 per week, from September 1, 2011 through March 17, 2013, inclusive, and from April 22, 2013 through July 8, 2013, inclusive, with credit for all amounts previously paid, as set forth in the attached decision.

The claimant's requests for maintenance benefits and vocational rehabilitation, as well as the claimant's requests for penalties and fees, are denied for reasons set forth in the attached decision.

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

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

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

Signature of Arbitrator

7-2-2014
Date

ICArbDec19(b)

JUL 2 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEWAYNE WALKER,	)	
	)	
Petitioner,	)	
	)	
vs.	)	No. 11 WC 37638
	)	
ILLINOIS MEDI-CAR, INC.,	)	
	)	15IWCC0629
Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Section 19(b) of the Act.

STATEMENT OF FACTS

The petitioner, 46 years old on the date of loss, is a high school graduate who was working as Medi-Car transport driver when the accident occurred on August 25, 2011. Prior to his employment with the respondent, he had worked as a pressman after graduating high school, then took a job with Zenith on their assembly line. He worked at Zenith for about ten years before their factory closed. After that, he worked at Home Depot and at a frozen food storage facility before his employment with the respondent.

On August 25, 2011, he was picking a patient up from MacNeal Hospital to bring the patient home. The patient had undergone knee surgery and could not walk. The petitioner and an assistant were bringing the patient into the patient's apartment, and while maneuvering the patient up a flight of stairs, the petitioner felt pain in his lower back radiating down the left side of his body. He contacted his supervisor after getting the patient into the apartment. Accident and notice were undisputed.

The petitioner presented to Dr. Huq on September 1, 2011. Dr. Huq prescribed him off work, gave him medication and prescribed an MRI. The MRI was conducted the next day, September 2, 2011, and noted multilevel disk bulging and degeneration as well as a disk herniation at L5-S1 with stenosis at that level. See generally PX2.

On September 16, 2011, Dr. Huq maintained the claimant off work and prescribed a course of physical therapy. The petitioner began the PT course on September 21, 2011. He remained in that treatment course through December 2, 2011; while the reports note improved range of motion and function, he continued to complain of pain. See PX2.

Dr. Huq referred the claimant to Dr. Lichtenbaum, a neurosurgeon, for evaluation.

The petitioner reported epidural injections had been attempted without relief of pain. The petitioner complained of significant pain which prevented a physical examination. Dr. Lichtenbaum reviewed the MRI films and noted "mild lumbar degenerative disease without significant canal compromise or neuroforaminal stenosis." Dr. Lichtenbaum opined surgery was unlikely to be of benefit and suggested nonsurgical pain control, but also discussed EMG testing for diagnostic purposes. See generally PX1. The petitioner never followed up with Dr. Lichtenbaum.

The petitioner thereafter undertook a treatment course with Dr. Kern Singh, who performed L5-S1 fusion surgery to address spinal stenosis and retrolisthesis on March 6, 2012. See PX3. The petitioner was prescribed postoperative physical therapy, which he underwent at ATI. PX4. On June 13, 2012, he was released to light duty by Dr. Singh. PX3. He apparently attempted to return to work the next day and had a recurrence of symptoms. PX3, PX4.

Imaging studies were conducted on June 18, 2012; the report is not present, but the claimant reported to his therapist that it was an MRI (see PX4, June 19 appointment) and a later CT scan was compared to a CT scan dated June 18, 2012. See PX3. In July 2012, Dr. Singh recommended a myelogram, which was performed on August 14, 2012; it revealed some bone fusion with no stenosis or extradural defect, but with epidural fibrosis narrowing the right S1 nerve root sleeve. See PX3.

On August 30, 2012, the respondent commissioned a Section 12 examination with Dr. Alexander Ghanayem. Dr. Ghanayem reviewed the CT myelogram results and opined that there was ectopic bone formation extending into the neural foramen on the right side at L5, and he opined that the bone formation was likely a complication from the March 2012 surgery. He recommended cessation of therapy and undertaking surgical decompression of the nerve root. See RX1.

On November 6, 2012, Dr. Singh performed revision L5-S1 foraminotomy and fusion surgery. See PX3. The petitioner was again prescribed postoperative therapy, which he performed at ATI. PX4.

On March 11, 2013, the petitioner saw Dr. Singh. He reported some improvement in therapy but complained of intermittent low back pain radiating to his right buttock and thigh. X-rays noted good bone consolidation and Dr. Singh prescribed another month of physical therapy and light duty with a 10 pound restriction and minimal bending, stooping and squatting. PX3.

On March 14, 2013, the respondent made a written offer of light duty to the petitioner. RX4. The petitioner did return to work thereafter.

On March 18, 2013, the petitioner underwent a repeat Section 12 evaluation with Dr. Ghanayem. The petitioner reported residual soreness with right leg symptoms. Examination noted the petitioner was neurologically intact. The petitioner reported using a cane (which had not been prescribed). Dr. Ghanayem recommended securing a lumbar

CT scan to evaluate the progress of the bone fusion solidifying and concurred with the light duty recommendations. He opined the petitioner was not yet at MMI. See RX2.

On March 25, 2013, Dr. Singh noted the petitioner was complaining of additional symptoms. He gave the petitioner a no driving restriction, recommended additional PT and otherwise maintained the claimant on light duty. PX3.

On March 27, 2013, the respondent issued a letter to the petitioner advising that they would provide transportation to and from work and maintain the light duty position. See RX7.

The petitioner saw Dr. Singh on April 8, 2013. He reported persistent low back pain radiating down the right leg. A CT scan was performed that day and was compared to the June 18, 2012 CT scan. It noted the expected postoperative changes and suggested that the bony fusion was not yet complete. Dr. Singh prescribed ongoing therapy. PX3. While during this period the petitioner had presented to light duty with a cane and had been noted to be using a cane at physical therapy, the petitioner was questioned about it at trial and admitted that Dr. Singh did not prescribe the cane and had in fact advised against its use, noting it would likely prolong the healing process.

On April 22, 2013, Dr. Singh noted reduced pain, but the petitioner asserted that he was only able to sit, stand or walk for about ten minutes at a time. Dr. Singh prescribed the petitioner off work and instructed him to participate in physical therapy for another four weeks. It was noted that at the end of that time, he would likely order an FCE followed by a work conditioning program. See PX3.

For approximately a week in May, the petitioner traveled by car to Omaha, Nebraska, for a family function. The petitioner testified he was still under a no driving restriction at that time. During that time the vehicle the petitioner was driving in was pulled over by a state trooper en route to Omaha, and the respondent had commissioned surveillance while the claimant was in Omaha. See RX5, RX12, RX15, RX17. The Arbitrator will render further comment and analysis about these issues below.

On May 16, 2013, Dr. Ghanayem reviewed additional records and the updated CT films from April 2013, but did not actually examine the claimant. He authored a report in which he opined the fusion was not particularly robust but also was not a failed fusion, as bony fusion was identified on multiple sagittal images. The films did suggest ongoing nerve root compression at L5-S1, which Dr. Ghanayem opined would likely be nonresponsive to physical therapy. He recommended sedentary level work and believed the petitioner could drive, but did not opine as to MMI in this report. See PX9, RX3.

On June 6, 2013, the petitioner underwent an FCE which suggested the claimant was presently able to work at the light physical demand level. It was noted that the petitioner was scheduled to undertake a work conditioning program thereafter. PX5.

The physical therapy reports include records of the work conditioning program beginning on June 12, 2013. PX4. By June 30, 2013, the petitioner was noted to have progressed to the point where he could lift and carry 40 pounds and do 30 pounds lifting overhead for 10 repetitions, placing him in the light-to-medium capacity. However, the petitioner had missed his appointments that week and he was discharged from the program due to failure to attend. PX4. The petitioner's attendance, or lack thereof, at the work conditioning was another area of contention, which will be further addressed below.

On July 8, 2013, Dr. Singh noted the petitioner had completed work conditioning on June 30, 2013, having progressed to the light to medium level. X-rays showed good hardware positioning. Dr. Singh released the petitioner to work at MMI with restrictions delineated in the work conditioning discharge report of June 30, 2013. PX3.

The respondent issued a letter dated July 29, 2013, offering the claimant a permanent position as a Porter, which would have paid the same rate as the petitioner's prior position, $12.06 per hour. Porters would need to wash and clean the exterior and interior of the vehicles and perform equipment checks to ensure function of the equipment. A physical demand and job requirement was submitted delineating the job demands. See RX8, RX9. The claimant did not accept this position; the circumstances regarding his non-acceptance of the position, as well as the degree to which the position would have been acceptable given the claimant's restrictions, were disputed, and will be discussed further below.

The petitioner testified that he has not worked since that offer was made. He did not submit any job logs or detail efforts made to secure additional employment. The claimant requests vocational assistance and job placement, as well as maintenance benefits through the trial date.

ANALYSIS

The petitioner returned to work on or about March 18 following an offer of light duty work. Shortly thereafter, at the petitioner's request, he was prescribed a no-driving restriction by Dr. Singh. The respondent immediately amended their earlier light duty offer to include transportation to and from their facility. The petitioner nevertheless described persistent pain to Dr. Singh along with inability to sit for any prolonged period. See generally PX3, RX4, RX7.

Shortly thereafter, the petitioner requested to cash in "safety points" from their employee incentive program to make a reservation at a Holiday Inn in Omaha, Nebraska, from May 9 to May 14, 2013. See RX5.

The petitioner acknowledged that he traveled from the Chicago area to Omaha in an SUV, but testified that he did not drive either to Omaha or while he was there. Rather, he testified, he rode with his male adult cousin, who did the driving. On cross-examination, he was confronted with traffic tickets he received on May 8, 2013, while

driving on I-88 near Rock Island en route to Omaha. See RX15. The petitioner then asserted that his cousin was actually driving, but did not have a driver's license; in order to prevent his cousin from being arrested, he and his cousin bribed the state trooper with $200.00 and gave the trooper the petitioner's driver's license, which was at the time suspended as well[1].

In response to the petitioner's above testimony, the respondent called Mr. Lloyd Murphy, an Illinois State Police Master Sergeant who had retired in January 2014. Mr. Murphy testified he was the arresting officer regarding the traffic ticket, and that on May 8, 2013, he was assigned on road patrol and traffic enforcement. At approximately 9:00 p.m. on May 8, 2013, he stopped a white Chevy Tahoe for speeding at 89 miles per hour in a 65 m.p.h zone. Mr. Murphy testified he approached the vehicle and the driver was the claimant, who identified himself with an Illinois driver's license. Mr. Murphy testified that the claimant was the only adult male in the vehicle, and he was accompanied by a female adult and three children. Mr. Murphy was asked about the petitioner's claim that a bribe was offered to allow another adult male to go free, and Mr. Murphy denied any such interaction, and also denied that any other adult male was present. Mr. Murphy testified that the entire traffic stop was recorded on the police car dashboard camera, which was published at the March 10, 2014 hearing and admitted as RX17. The video clearly shows the petitioner exiting the driver's side door of the vehicle.

The respondent called Ms. Julie Aksamit to testify. She testified that she was retained to conduct surveillance of the petitioner while he was in Omaha. She secured video of the petitioner while he was there, which was introduced as RX12. The video shows an adult male resembling the claimant; the claimant attempted to claim it was actually his twin brother who had been seen by the investigator. The Arbitrator notes that while the claimant and his brother are strikingly similar in appearance, the claimant appeared somewhat more heavyset on the hearing date, and the videotaped individual more closely resembled the claimant. Moreover, the individual on the Omaha tape was observed there in the vicinity of the SUV and the female adult which were shown on the video of the traffic stop. The Arbitrator finds that it is more likely than not that it was the claimant, not his brother, who was identified by Ms. Aksamit.

The respondent inquired on cross-examination as to the claimant's use of a cane against his doctor's advice, as well as the petitioner's attendance issues at the work conditioning and his discharge for failure to present. The claimant asserted that the respondent had not paid for or approved the medical care. However, the medical billing demonstrates that regular payments had been made throughout the course of the case, undermining any such assertion. See RX14.

The respondent called Mr. Jobin Joseph, the respondent's HR Manager, to testify regarding the light duty offer of a Porter. Mr. Joseph testified that the Porter position was the only permanent position they had available which would accommodate the

[1] The Arbitrator notes that for the petitioner's rendition of events to be true, the claimant's actions would have extended far beyond the May 8th encounter, as on July 24, 2013 he pled guilty to a misdemeanor charge of Driving While License Suspended, pursuant to §625 ILCS 5/6-303(a). See RX15.

petitioner's lifting restrictions. The claimant testified that he felt he could not do the job to the best of his ability; he did not accept the Porter job and ceased work for the respondent thereafter. Mr. Joseph testified that the offer was made to the claimant and the claimant immediately responded that the position was beneath him and he did not want to go from a driver's position to one where he had to wash vehicles.

The Arbitrator has fully considered the medical and factual records as well as the substance and manner of the claimant's testimony, and notes multiple instances where the petitioner demonstrated a lack of both veracity and forthrightness. The Arbitrator finds the petitioner has demonstrated a serious credibility deficit. This assessment informs the Arbitrator as to all issues in dispute.

OPINION AND ORDER

Causal Connection to the Injury

A claimant has the burden of proving by the preponderance of credible evidence all elements of the claim. See, e.g., *Seiber v. Industrial Commission*, 82 Ill.2d 87 (1980). The initial accident was not disputed, and there appears to be a general consensus that the fusion surgery and the subsequent revision procedure were causally related to the injury. While Dr. Lichtenbaum's prediction that surgery might prove to be of limited benefit appears to have been prescient, the surgery undertaken does appear to have been targeted at objective pathology which was aggravated by the accident at issue herein. As such, the Arbitrator finds a casual relationship to the surgeries has been established.

Having so found, the petitioner's aforementioned credibility deficit renders the extent of residual complaints, and any prescriptions or restrictions based on those complaints, highly suspect. While the right to recover benefits cannot rest upon speculation or conjecture (see *County of Cook v. Industrial Commission*, 68 Ill.2d 24 (1977)), currently requested benefits based on the causally related surgeries will be addressed in each individual section, below.

Medical Expenses

The medical services provided appear reasonably medically necessary. While the respondent submitted Utilization Reviews suggesting some of the physical therapy in 2011 and 2013 was excessive (see generally RX6), the Arbitrator notes that in 2011 the treating physicians were seeking to avoid surgery and the treatment in 2013 was broadly aimed at postoperative recovery. The claimant's efforts in postoperative therapy were clearly substandard, as evidenced by his persistent use of a cane in contravention of his physician's orders as well as his failure to present at work hardening; nevertheless, the treatment rendered appears to be medically reasonable.

The Arbitrator does note that the ATI bill submitted as PX11, asserting $4,768.18, is not presently supported. The respondent submitted an ATI account sheet as RX14, which demonstrates more recent information than PX11, and which shows a zero balance remaining at that point. As such, the request for the ATI medical expenses is hereby denied, as it appears this would represent a duplicate payment.

The respondent shall pay the outstanding balances of the Advanced Physical Medicine Centers (see PX7), being $6,442.64, but subject to the limits of Section 8.2 of the Act, as these costs appear reasonable, necessary and related to the injury. At the petitioner's request, these amounts shall be paid to the petitioner via counsel, and the provider shall seek recompense from petitioner and counsel rather than the respondent.

Temporary Total Disability and Maintenance

As these issues overlap, the Arbitrator will address them jointly. The claimant submits a request for TTD for the periods from September 1, 2011, through March 17, 2013, and from April 22, 2013, to July 12, 2013. He further requests maintenance from August 9, 2013 through the final trial date of May 12, 2014. See Arb.Ex.I.

Based on the credible medical evidence, the petitioner has demonstrated eligibility for TTD for the period from September 1, 2011, through March 17, 2013, inclusive, and the Arbitrator awards this period.

While the petitioner's claims of disability from April 22, 2013 through July 12, 2013 appear to be based in large part on his exaggerated and dubious complaints, such as those which prompted a "no driving" restriction that the petitioner flagrantly violated, there does appear to be objective evidence substantiating inability to perform his usual and customary pre-injury work activities. The Arbitrator finds that TTD eligibility would cease on July 8, 2013, when Dr. Singh pronounced the claimant at Maximum Medical Improvement; disability following that date would be permanent in nature. Compare *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, 266 Ill.2d 132, 923 N.E.2d 266 (2010). As such, the Arbitrator awards the claimant TTD from April 22, 2013 through July 8, 2013, inclusive.

Regarding maintenance from August 9, 2013, through the final date of trial, the Arbitrator has reviewed the job offer in detail, the testimony of Mr. Joseph, as well as the petitioner's work restrictions and the claimant's testimony and the claimant's credibility. The petitioner's attempt to suggest that the job offer might conflict with the FCE is misleading; the FCE was prior to the work conditioning program, not following it. As such, the FCE was clearly not designed as an attempt to determine the petitioner's permanent restrictions, and Dr. Singh made that clear in his discharge report. The Arbitrator finds that the job offer was within the claimant's physical capacity and was made in good faith. The claimant never attempted to perform it. Moreover, Mr. Joseph's testimony that the claimant rejected it for his own personal reasons rather than reasons related to his medical condition appears credible. This assessment is reinforced by the

fact that the claimant has not sought any work since his refusal of the Porter position; this also undermines any claim to maintenance based on a self-directed job search, which has clearly not been undertaken by the petitioner. Accordingly, the Arbitrator denies the request for maintenance.

In summary, the claimant has demonstrated eligibility for 646 days of TTD as delineated above, or 92 & 2/7 weeks, at the appropriate TTD rate of $319.00 per week (statutory minimum rate). This is a total liability of $29,439.14. The respondent is provided credit for $31,250.36 in disability benefits paid to date; the $1,811.22 in excess disability benefits shall be credited against any further permanent disability award.

Vocational Rehabilitation

In addition to the maintenance request as previously discussed, the petitioner seeks vocational assistance. The claimant has rejected a good faith job offer and has been conclusively shown to lack credibility. He has produced no credible evidence, either testimonial or documentary, of any sort of job search or vocational counseling effort. Even had his credibility not been wholly lacking, this is unacceptable under *National Tea Co. v. Industrial Commission*, 97 Ill.2d 424 (1983) and *Roper v. Industrial Commission*, 349 Ill.App.3d 500 (5th Dist. 2004) and does not meet the requirements to establish a vocational benefit program. The request is denied.

Penalties and Fees

Imposition of penalties is to be considered based on the basis of reasonableness. See, e.g, *Avon Products, Inc. v. Industrial Commission*, 82 Ill.2d 297 (1980); *Smith v. Industrial Commission*, 170 Ill.App.3d 626 (3rd Dist. 1988). In the *Avon* case, the Court looked to Larson on Workmen's Compensation for guidance, noting penalties for delayed payment are not intended to inhibit contests of liability by employers who honestly believe an employee is not entitled to compensation. 3 A. Larson, Workmen's Compensation sec 83.40 (1980). Here, the respondent's dispute was clearly reasonable and not vexatious in character. Penalties and fees are inappropriate.

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

Illinois Workers' Compensation Commission,
Insurance Compliance Division,

Petitioner,

vs. NO: 13 INC 457

Golebiowski's Transport, Inc. and Tomasz Golebiowski, Individually and as President of, And Halina Golebiowski, Individually, and as Secretary of Golebiowski's Transport, Inc.,

15IWCC0630

Respondents.

DECISION AND OPINION REGARDING INSURANCE COMPLIANCE

Petitioner, the Illinois Workers' Compensation Commission, Insurance Compliance Division, brings this action, by and through the Office of the Illinois Attorney General, against the above captioned Respondents, alleging violations of Section 4(a) of the Illinois Workers' Compensation Act. Proper and timely notice was provided to the Respondents and a hearing was held before Commissioner Michael J. Brennan in Chicago, Illinois on August 7, 2015.

Petitioner alleges that Respondents knowingly and willfully lacked workers' compensation insurance coverage a minimum period of 1,683 days, from December 29, 2010 through August 7, 2015.

After considering the entire record, the Commission finds that Respondents knowingly and willfully violated Section 4 of the Act during the period in question and shall pay a fine of $841,500.00 and cease all business operations at the place of employment until proof of insurance is provided under the Act pursuant to Section 4(d).

FINDINGS OF FACT AND CONCLUSIONS OF LAW:

1. Frank Capuzi, chief of the compliance investigators for Petitioner and an investigator, testified at the August 7, 2015 hearing.

2. Investigator Capuzi was notified that Respondents did not have workers' compensation insurance as a result of a claim, 13 WC 21803, filed with the Illinois Workers' Compensation Commission that the Injured Workers' Benefit Fund was named a party to due to Respondent business' lack of insurance.

3. Investigator Capuzi then inquired with the Office of the Secretary of State for the State of Illinois and found that Golebiowski's Transport, Inc. incorporated July 30, 2001. The Articles of Incorporation for the business indicated that the incorporating persons were Marian Golebowski, Michal Golebiowski, and Kazimerz Golebowski. (PX1) Investigator Capuzi also requested the Annual Reports from Respondent business which listed Tomasz Golebiowski as President and Halina Golebiowski as Secretary of Respondent business. (PX2)

4. Investigator Capuzi checked the National Council on Compensation Insurance's (hereinafter "NCCI") database, and confirmed that Respondent business was not carrying workers' compensation insurance. NCCI showed that Respondent business's workers' compensation insurance had expired in December of 2010. (PX4) According to the report from NCCI, Respondent business' workers' compensation insurance was most recently canceled on December 29, 2010 for failure to comply with the terms of an audit. (PX4) Investigator Capuzi also checked the Self-Insurance database and found that Respondents are not self-insured. (PX5) Finally, Investigator Capuzi searched the SAFER database, which is run by the U.S. Department of Transportation. Trucking companies are required to report certain information to SAFER, including how many trucks and drivers the company has. The SAFER database indicated that Golebiowski's Transport, Inc. reported having 24 power units and 54 drivers as of July 9, 2015. (PX6)

5. A Notice of Non-Compliance was sent to Respondents in the Fall of 2013 notifying Respondents that they are required by law to show proof of compliance with Section 4 of the Illinois Workers' Compensation Act and holding that as of December 29, 2010 to the present the records of the Illinois Workers' Compensation Commission showed that Golebiowski's Transport, Inc. was not in compliance with the Act.

6. After the requisite period to respond and show proof of compliance had lapsed, a Notice of an Insurance Compliance Hearing was sent to Respondents indicating a hearing on the issue had been scheduled.

7. Respondents' counsel sent a response on January 15, 2014, requesting the hearing be continued to February 26, 2014. The request was granted and on February 26, 2014, the hearing was again continued to March 19, 2014 and on April 30, 2014. Throughout this

time, Investigator Capuzi spoke to Respondents' counsel numerous times regarding the procurement of workers' compensation insurance.

8. On October 21, 2014, Investigator Capuzi met with Respondents' counsel and notified him that Respondents had 30 days to obtain workers' compensation insurance. On December 2, 2014, Respondents' counsel claimed that Respondents could not afford to get workers' compensation insurance. The matter was set for trial in May of 2015. Golebiowski's Transport, Inc. has continued to operate without insurance.

9. On July 16, 2015, Investigator Capuzi personally served Golebiowski's Transport, Inc. at the 6200 West 51st Street location with the Emergency Motion for Work Stop Order notifying Respondents of the hearing to be held on August 7, 2015. Investigator Capuzi also noted that Golebiowski's Transport, Inc. was operating and open for business.

10. A Review Hearing was held on August 7, 2015. At that time, Investigator Capuzi testified as to his investigation. Investigator Capuzi testified that he searched the afternoon before the hearing and the morning of the hearing to see if Respondents had obtained workers' compensation insurance and found that they had not.

11. The Commission admitted the following Petitioner's exhibits into the record:

PX1, the Articles of Incorporation for Golebiowski's Transport, Inc.

PX2, the Annual Reports filed with the Illinois Secretary of State for Golebiowski's Transport, Inc.

PX3, a letter from the Illinois Department of Revenue enclosing copies of available Illinois Small Business Corporation Replacement Tax Returns filed from 2008 through 2012 for Golebiowski's Transport, Inc. and letters certifying that no Illinois Small Business Corporation Replacement Tax Returns were filed for Golebiowski's Transport, Inc. for 2013 and 2014 or Illinois Employers' Quarterly Withholding Income Tax Returns for September 2010 or June 2015.

PX4, the printout from NCCI showing that Golebiowski's Transport, Inc.'s workers' compensation insurance had been canceled December 29, 2010.

PX5, a letter of certification from the Illinois Workers' Compensation Commission's Office of Self-Insurance Administration indicating that Golebiowski's Transport, Inc. is not self-insured.

PX6, the printout from the SAFER database.

PX7, the affidavit of service signed by Investigator Capuzi and Notice of Motion and Emergency Motion for a Stop Work Order.

15IWCC0630

12. The Commission admitted the following Respondent's exhibits into the record:

RX1, proof of occupational, but not state-approved coverage, insurance obtained by Golebiowski's Transport, Inc. on August 6, 2015.

Respondents were put on notice by Investigator Capuzi of the legal requirement to carry workers' compensation insurance on Golebiowski's Transport, Inc. back in 2013, yet as of the date of hearing, about two years later, Respondents still have not obtained said coverage. Respondents further failed to offer any defense at hearing for the fact that the business had been operating without the mandated coverage. The Commission finds Respondents willingly and knowingly violated Section 4 of the Illinois Workers' Compensation Act. The Commission orders Respondents to pay $841,500.00 under Section 4(d) of the Act. The Commission also finds that Respondents' failure to provide coverage under Section 4(d) of the Act is an immediate serious danger to public health, safety and welfare sufficient to justify a work-stop order requiring cessation of all business operations of Respondents at the place of employment until proof of insurance is provided under the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondents Golebiowski's Transport, Inc., and Tomasz Golebiowski, Individually and as President of, and Halina Golebiowski, Individually, and as Secretary of Golebiowski's Transport, Inc., pay to the Illinois Workers' Compensation Commission the sum of $841,500.00, pursuant to Section 4(d) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondents Golebiowski's Transport, Inc., and Tomasz Golebiowski, Individually and as President of, and Halina Golebiowski, Individually, and as Secretary of Golebiowski's Transport, Inc., cease all business operations until proof of insurance required by the Act is provided, pursuant to Section 4(d) of the Act.

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

DATED:
MJB/ell AUG 18 2015
H-08/07/15
52

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamboth

STATE OF ILLINOIS)
) SS.
COUNTY OF)
LASALLE

- ☐ 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

John Winters,
Petitioner,

vs.

NO: 10 WC 38523

15IWCC0631

Tennant Truck Lines,
Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission pursuant to remand Order of the Circuit Court of LaSalle County for a determination of an amount for further medical benefits to be awarded for a second left shoulder surgery and for temporary total disability benefits previously claimed to be related to that second surgery.

In his Decision filed July 19, 2013, Arbitrator Andros found that an employment relationship existed between Petitioner and Respondent on September 6, 2010 and that Petitioner sustained accidental injuries arising out of and in the course of his employment on that date. However, the Arbitrator found that Petitioner's current condition of ill-being is not causally related to those injuries in that an intervening accident occurred on April 8, 2011 which broke the causal chain. Petitioner had continued to work until he was terminated on September 24, 2010 in a dispute with Respondent over cleaning the cab of the truck he drove. The Arbitrator found Petitioner failed to prove he was temporarily totally disabled from September 25, 2010 until January 21, 2011, the date of a first left shoulder surgery. The Arbitrator found temporary total disability from January 22, 2011 through May 22, 2011, the date the Arbitrator found Petitioner to be at maximum medical improvement, 17-3/7 weeks at $587.38 per week. Regarding nature and extent of permanency, the Arbitrator found that Petitioner sustained a left rotator cuff injury to his non-dominant extremity and underwent surgery on January 22, 2011. Petitioner slipped and fell on a bar of soap in his home shower on April 8, 2011. The Arbitrator found that this did not change Petitioner's left shoulder condition, but that he injured his right shoulder. The Arbitrator found no causal relationship exists for a second left shoulder surgery that was performed on August 29, 2011. The Arbitrator awarded permanent partial disability of

10% man as a whole on the face sheet and 11.75% man as a whole in the body of the Decision, at $528.64 per week. The Arbitrator did not award medical expenses after April 8, 2011. The Arbitrator found the testimony of Respondent's CEO Mr. Tennant very credible and Petitioner's testimony incredible.

Petitioner reviewed the Arbitrator's Decision on the issues of causal connection, extent of temporary total disability, nature and extent of permanent disability, medical expenses, intervening accident and termination of employment. In its Decision and Opinion on Review dated August 25, 2014, the Commission corrected the face sheet to reflect the permanency award of 11.75% person as a whole as indicated in the body of the Arbitrator's Decision and otherwise affirmed and adopted the Decision of the Arbitrator.

Petitioner appealed the Commission's Decision and Opinion on Review to the Circuit Court of LaSalle County. On May 13, 2015, Circuit Court Judge Eugene P. Daugherity entered an Order finding that the Commission's decision of no medical causation for Petitioner's second surgery was against the manifest weight of the evidence, since the second surgery was based on an MRI which appeared to show a damaged anchor from the first surgery. However, Judge Daugherity found that the Commission's findings on the nature and extent of Petitioner's injury were not against the manifest weight of the evidence and were upheld. Judge Daugherity remanded the case back to the Commission for determination of further medical benefits to be awarded for the second surgery and for related temporary total disability benefits previously claimed related to the second surgery.

On remand, the Commission finds Petitioner was temporarily totally disabled for an additional period from August 29, 2011, the date of the second left shoulder surgery, through May 15, 2012, the date Dr. Gunderson found Petitioner to be at maximum medical improvement, 37-2/7 weeks at $587.38 per week, and finds that Respondent is liable for the medical expenses for the second left shoulder surgery for the reasons set forth below.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner testified at the August 29, 2012 arbitration hearing that he became employed with Respondent in September or October 2008. He was hired to drive a truck and load and unload farm equipment (Tr 6-7). Prior to working for Respondent, Petitioner was a truck driver for 40 years (Tr 7). Fifteen to eighteen years ago, he also trained through the Illinois Valley Community College to operate a waste treatment facility (Tr 7). After that, Petitioner worked for about a year at LaSalle Rolling Mills on a cyanide plating line (Tr 8). Other than that, Petitioner only worked at truck driving (Tr 8).

On September 6, 2010, Petitioner was driving a loaded trailer in the state of Maryland (Tr 8). He had a 2-stop load on the trailer. The first stop was a skid steer that went to a John Deere dealer and the second stop was a large John Deere tractor (Tr 8). Petitioner had no left shoulder injury or symptoms on the morning of September 6, 2010 (Tr 9). He made the first delivery with no problems. The large John Deere tractor had 8 chains and 8 binders holding it to the trailer. One of the binders was a snap binder, which snapped over to lock in place and had a bent handle on it. The dealership was in a hurry for Petitioner to unload the tractor and he hurried to get it undone (Tr 9). Petitioner had a hard time with the binder with the bent handle, getting it to release by putting a cheater pipe on it and it was bend so badly that it curled down underneath the chain. Petitioner tried to force the cheater pipe onto it and ended up swinging to get the pipe onto the binder and finally got it, but in the process felt pain in his left shoulder (Tr 10). Petitioner was finally able to get the tractor unloaded (Tr 10). The pain was in the left shoulder joint (Tr 10). Petitioner called dispatcher Rick to arrange for his next load and told him that he had injured his left shoulder (Tr 11). Rick told Petitioner what his next load was going to be. Petitioner continued working (Tr 11). The next morning, Petitioner reloaded and left Maryland. It was about two weeks before Petitioner returned to the terminal in Illinois (Tr 12). During those two weeks, Petitioner did not seek medical treatment because, "dispatch just kept me running." (Tr 12).

When Petitioner returned to the Illinois terminal, he talked to Respondent's office manager Sandy. He thought Rick was also present during this conversation. Petitioner told Sandy that he had hurt his left shoulder and that he told Rick at the time and Rick confirmed that (Tr 13). Petitioner stated that Sandy referred him to a doctor's office; this was not Petitioner's choice of physician (Tr 13-14). Petitioner ultimately got to Dr. Gunderson, who ended up performing a rotator cuff surgery on his left shoulder (Tr 14). He attended post-operative physical therapy. Following the surgery, Petitioner had improvement at first (Tr 14-15). Petitioner's attorney showed him Dr. Gunderson's office notes from March 11, 2011, Px9, and at that time, Dr. Gunderson indicated Petitioner seemed to be doing reasonably well (Tr 15). Petitioner stated that on March 11, 2011, he continued to have left shoulder pain. Prior to March 11, 2011, at no time had his left shoulder condition returned to the state it was in prior to the September 6, 2010 incident (Tr 15).

Petitioner was shown Dr. Gunderson's office notes from April 8, 2011 (Tr 16). Petitioner saw that in that note it stated that on his last physical therapy evaluation on April 5, 2011, he was doing very well (Tr 16). Petitioner saw that the note stated further that he had recently had a fall on his left shoulder that increased his pain (Tr 16). Petitioner explained that on April 8, 2011, he was at home and trying to get into the shower with use of only one arm. There was some soap in the bottom of the tub. Petitioner's feet slipped and he fell down inside the tub (Tr 16-17). When this occurred, Petitioner did not notice any more pain than he was having anyway. Subsequently, Petitioner returned to Dr. Gunderson who he was already planning on seeing anyway (Tr 17). Ultimately, Dr. Gunderson performed a second surgery on his left shoulder (Tr 17). Petitioner attended post-operative physical therapy (Tr 17). Petitioner underwent a functional capacity evaluation and was released by Dr. Gunderson within the confines of that evaluation (Tr 18).

Petitioner testified that when he had returned to the Illinois terminal and was sent to a doctor by Sandy, he continued to work for 2 to 3 days (Tr 18). After that, Petitioner walked into Respondent's office and they told him he was fired (Tr 19). When he walked into the office, Aaron Tennant, the owner of Respondent, and Sandy were present (Tr 19). Petitioner also believed Rick the dispatcher was there and is certain one or two others were there, including a truck driver (Tr 19). He did not know the names of these other people (Tr 19). He had gone into the office that day to turn in some paperwork because he had just gotten back from hauling a load in (Tr 20). When he entered the office to turn in the paperwork, Aaron Tennant spoke and told Petitioner he was letting him go because he found something in the truck that should not have been there. Petitioner asked Mr. Tennant if that meant he was firing him and he said yes (Tr 20). At that time, Petitioner did not know what Mr. Tennant was referring to when he said he had found something in the truck that should not have been there and Mr. Tennant did not tell Petitioner what he had found at that time (Tr 20). Previously, Mr. Tennant had discussed with Petitioner the cleanliness of the truck he drove (Tr 21). Regarding this previous discussion, Petitioner explained that he has a small bladder and has to urinate often. To do so, he was urinating into an ice tea bottle so he would not have to keep stopping while going down the road (Tr 21). Petitioner was aware of a company policy that lays out guidelines for the cleanliness of the truck he drove (Tr 21). Petitioner knows this was a violation of that policy, but it was either do that or stop every hour or so to go to the bathroom (Tr 22). Petitioner was aware he was violating company policy at that time (Tr 22). The first instance Petitioner was disciplined by receiving a $500 bill for cleaning the truck (Tr 22). In the conversation with Mr. Tennant 2 or 3 days after returning from the east coast, Petitioner did not believe Mr. Tennant discussed with him the cleanliness of the truck he was driving, but he might have (Tr 22). After the first fine, Petitioner continued to use bottles to urinate in or have other items in the truck (Tr 23). He did that because he had to urinate and so instead of stopping, he used a bottle while he was driving (Tr 23). On the date he had this conversation with Mr. Tennant, Petitioner did not quit his job (Tr 23). He did not ever walk off the job site. He did not ever threaten to sue Respondent (Tr 23). Petitioner did not immediately leave the area after he believed he was told that he was terminated; he called his wife and told her to come and get him and in the meantime, he picked up his stuff (Tr 23). After he was terminated, Petitioner was at the terminal for at least 2 hours (Tr 23-24). He did not walk off the job site and leave immediately (Tr 24). No one came out to talk to him during those 2 hours (Tr 24). No one came out to tell him that he could still be employed there if he wanted to be (Tr 24). The day after this conversation, Petitioner did not believe he had the right to go back and work at Respondent because Mr. Tennant had told him he was fired (Tr 24). If Mr. Tennant had not told him that, Petitioner would have shown up for work the next day (Tr 24).

Prior to the incident in question, Petitioner had no plans to retire (Tr 25). He had planned on working to at least age 70 because he wanted to build up his Social Security (Tr 25). When he was released on the functional capacity evaluation restrictions, Respondent did not offer him a job at that time (Tr 25). In June 2012, Petitioner was offered by Respondent a driving job again and a gate guard position (Tr 25-26). At that time, Petitioner did not accept the truck driving job because Dr. Gunderson told him he would not be able to climb up into the truck cab. If Dr.

Gunderson had said he was able to climb into the truck cab, Petitioner would have taken the truck driving job offer because he enjoyed hauling oversized equipment and enjoyed meeting various people (Tr 27). Currently, if he could be driving a truck, he would do so (Tr 28). Petitioner accepted the gate guard position, which duties involved letting people in or out through the gate (Tr 28). He had never done that work before for Respondent. Petitioner was paid $15 per hour for working the gate guard position and worked 40 hours per week and was able to perform that job (Tr 28-29). Petitioner identified Px17 as his last pay stub from being a gate guard (Tr 29). This was less than he was paid as a truck driver for Respondent (Tr 29). It was 49 miles one-way from his home to Respondent's terminal and it took him 1 hour and 10 minutes to get there (Tr 29-30). When he was a truck driver for Respondent, he did not have to travel that because he took the truck home when he was sent home (Tr 30). He did not have to commute every day when he was a truck driver (Tr 30). When he was a gate guard, he had to commute every day (Tr 30). Petitioner no longer works the gate guard position because of the commute, the cost of gas and having to work the night shift from 10:00 p.m. to 6:30 a.m. and he was unable to sleep during the day (Tr 31). He had not worked the night shift at Respondent before. Petitioner stopped working this job two weeks before the arbitration hearing (Tr 31). Petitioner never had to work the night shift for any truck lines over the 40 years of truck driving work (Tr 31). He worked the gate guard position for approximately 2 months (Tr 28).

Petitioner currently noticed that his left shoulder condition has never returned to the condition it was prior to September 6, 2010 (Tr 32). Physically he is capable of working, but he cannot raise his left arm up and has real sharp pain in his left shoulder (Tr 33). Petitioner used to fish a lot and used to do a lot of work around his house (Tr 33). He cannot cast a fishing pole. Petitioner is right hand dominant (Tr 33). He casts a fishing pole with his right arm (Tr 34). He can only do repair work around his house using his right arm. He cannot work on the porch that is falling off his house (Tr 34).

On cross-examination, Petitioner testified that when he first started working at Respondent, he was given an employee handbook and he looked it over at that time (Tr 35). Respondent's attorney showed Petitioner a page from the employee handbook, Rx1, and Petitioner read same (Tr 36). This page was part of the handbook he had (Tr 36). Petitioner acknowledged that under Equipment Section 3C 5, it states cleanliness of the interior of the cab of the tractor is the responsibility of the truck driver and that failure to maintain the interior of the equipment in a reasonably clean condition will be considered an abuse of equipment (Tr 36). Petitioner agreed that was what the rules were (Tr 37). Petitioner denied being written up by Respondent on at least 3 occasions for lack of cleanliness of his tractor (Tr 37). He believed he was written up 2 times for lack of cleanliness of his tractor (Tr 37). Petitioner denied that the reason he was written up was not because he was going to the bathroom in an ice tea bottle, but because he refused to clean the tractor (Tr 38). Petitioner was shown Rx2 and stated the document is something about disciplinary action dated February 9, 2010 and involved him (Tr 38). He has seen Rx2 before, but he did not know what all the chicken scratch on it was (Tr 39). He has seen the words "misuse of equipment" before. He did not know what cleanliness of equipment was supposed to mean, but stated "bodily fluids." (Tr 39-40).

Petitioner believed he was written up on February 9, 2010 for his truck being filthy and filled with debris, including bodily fluids (Tr 40). He believed Respondent told him to clean up his truck in February 2010, but he did not know the date (Tr 40). Petitioner cleaned up his truck as he was directed to do (Tr 40). Petitioner was shown Rx3 and read same (Tr 40-41). He acknowledged he had signed Rx3 (Tr 41). He acknowledged that Rx3 is another write-up that he received disciplinary action from Respondent on July 25, 2010 (Tr 41). He agreed that Rx3 states, "The truck was inspected. There was concern with cleanliness and instructed John to clean out the interior before leaving. Truck inspection at each terminal." (Tr 41). Petitioner acknowledged he had received this other warning that his truck was not clean (Tr 41). He cleaned the truck at that time before he left the yard (Tr 42).

Petitioner testified it is not true that he was written up again on September 26, 2010 (Tr 42). It was not his recollection that on September 24, 2010, Aaron Tennant told him to clean up his truck (Tr 42). Petitioner was shown photographs Rx5, Rx6 and Rx7 and stated that those photographs do not depict the inside of his truck in September 2010 (Tr 42). It did not look like his truck in the photographs, which were not accurate (Tr 42-43). Petitioner recalled his earlier testimony how he went to the bathroom in a bottle (Tr 43). An Aqua Fina bottle is shown in one of the photographs and Petitioner was asked if that was his and he stated, "Yes, it's very possible." (Tr 43). Petitioner stated that the photographs look like they show the inside of his truck at one time, but there were no dates on the photographs (Tr 43-44). His truck was not in the condition shown in the photographs on September 24, 2010 (Tr 44). No one at Respondent ever said anything about cleaning out his truck on September 24, 2010 because it was clean. The photographs could have been from before as there is no date on the photographs (Tr 44). Petitioner acknowledged that there were times when his truck was in the condition seen in the photographs and he was warned not to let that happen and he let it happen twice (Tr 44-45). Petitioner did not know that if he was written up 3 times, he could be terminated for that (Tr 45). He did not know if that was in the employee handbook or not (Tr 45).

Petitioner was in Maryland on a trip to the east coast for Respondent. He returned to Illinois approximately 2 weeks later, somewhere around September 20, 2010 (Tr 45). Petitioner was shown Rx9 and stated that it showed his loads in September 2010 (Tr 45-46). He then stated he was in Illinois before September 20, 2010 (Tr 46). According to the dispatch logs for his truck, Rx9, Petitioner was back in Illinois around September 9, 2010. Petitioner stated it looked like Rx9 appeared to be the dispatch logs for his truck in September 2010 (Tr 46). He had no reason to disagree with the dispatch logs indicating the trips that he ran for Respondent in September 2010 (Tr 46-47). According to his recollection and Rx9, Petitioner first came back to Illinois just a couple days after getting injured in Maryland on September 6, 2010 (Tr 47). In Illinois, he went to Peoria, about 50 miles from his home (Tr 47).

Petitioner was shown the records from Concentra which state that he was seen there on September 21, 2010 (Tr 47-48). Petitioner agreed that after the September 6, 2010 accident, he first sought treatment on September 21, 2010 (Tr 48). Petitioner acknowledged that he told the doctor at Concentra that he had injured himself approximately 2 weeks prior and that he was able

to continue driving with the injury and do his job (Tr 48). After being seen at Concentra on September 21, 2010, it is true that Petitioner drove lead for Respondent on September 22, 2010 (Tr 48-49). Petitioner stated that was not his regular job and the difference was van trailer as opposed to open top; in other words, light duty (Tr 49). Petitioner normally pulled farm equipment on an open trailer like a flat bed or step deck or a RGN using chains and binders (Tr 49). The van trailer he pulled on September 22, 2010 was essentially a drive only (Tr 49). On that date, Respondent made available to him a different job that involved driving only and he did that job (Tr 49-50). In his regular job as a flat-bed driver, Petitioner did not load and unload the freight, but he did secure the freight to the trailer using a chain (Tr 50). On September 23, 2010, Petitioner again drove a semi-truck with a box trailer which involved driving and no lifting (Tr 50). He took a load down to Missouri on that date and came back (Tr 51). Petitioner would agree that he was driving this semi-tractor trailer with the van (box) trailer drive only for Respondent over the road for a few days after he went to Concentra until he no longer was doing that based upon the dispute he testified to earlier (Tr 51). He would have continued doing that if it had not been for what he said was his termination by Mr. Tennant; "Yes, he fired me." But for that termination, Petitioner would have kept driving the semi-tractor with the van/box trailer, drive only (Tr 51). He was physically able to do that at the time (Tr 51). Petitioner was asked the following: "Q. And you were physically able to do that at the time right up until the point where you had your first surgery in January of 2011, true? A. Pretty much, yes." (Tr 51).

Petitioner testified he was fired on September 24, 2010. That same day, he was seen at Concentra again (Tr 52). He denied telling anyone at Concentra that he delayed reporting the accident because he felt it was his responsibility as a driver to work through it without complaining (Tr 52). As an over-the-road truck driver, Petitioner drove all over the country. He drove a lot more than 50 miles, he did not go home every night and he was on the road weeks at a time (Tr 53). Petitioner did not walk off the job on September 24, 2010 and he did not refuse to clean the truck (Tr 53). Petitioner was recovering from his January 2011 surgery when he fell at his house (Tr 53-54). It is not true that he had increased left shoulder pain after that fall (Tr 54). There was no increase in his left shoulder pain at any time after that fall (Tr 54). Petitioner did not tell his doctors that he had increased pain in his left shoulder after the shower fall (Tr 54). He underwent a second surgery to his left shoulder after that fall (Tr 55). He was not going to have a second surgery before that fall (Tr 55). The whole issue of a second surgery came up after the fall (Tr 55). Petitioner is no longer treating for his left shoulder (Tr 55). A functional capacity evaluation was done on April 16, 2012 at Accelerated Rehabilitation (Tr 55). He has reviewed the FCE report (Tr 56). The FCE report did not say he could physically work at the medium to heavy level (Tr 56). Petitioner was shown the FCE report, Rx10, and acknowledged that on Page 1, second paragraph under client occupation, physical demand level, he tested at medium to heavy (Tr 56-57). The report stated he is physically capable of bilateral lifting of 65 pounds, bilateral carrying of 65 pounds and bilateral shoulder lifting of 55 pounds (Tr 57). Petitioner disputed that and stated he can pick up 65 pounds by just moving his forearms and if he moves his shoulder, that is when he has the problem (Tr 58). Petitioner thought he could curl Respondent's attorney, who weighed 185 pounds, just with his forearms, but if he moved his shoulder, that causes him problems (Tr 58).

Petitioner quit working the guard job at Respondent's facility (Tr 59). Petitioner testified he told Mr. Tennant he was leaving in December 2012 to have right shoulder surgery (Tr 59). His right shoulder is bothering him (Tr 59). He told Mr. Tennant it would take 3 to 4 months to recover from right shoulder surgery (Tr 60). He did not tell him he was quitting for good and that he would be back in 3 to 4 months (Tr 61). Petitioner did not know what gate guards on the day shift make an hour and it would surprise him if he made more for the night shift (Tr 61). It is not true that he told Concentra on September 24, 2010 that he was ready to go back to his regular job and that he was much improved (Tr 61). Currently, Petitioner feels he is able to drive a truck, he just cannot get into a truck (Tr 62). Petitioner stated he cannot drive smaller trucks that he can get into because that does not pay as well (Tr 62). He can get into a step van because that just requires stepping up (Tr 62). Petitioner has not made any effort to look into some sort of mechanical assistance for getting into a semi-tractor trailer (Tr 62-63). The company would not hire him if he cannot get into a truck and he guessed that would be an extra expense (Tr 63). Petitioner agreed there is a shortage of truck drivers in the trucking industry now and companies need drivers (Tr 63). Truck driving is what he wants to do (Tr 63).

At Respondent's request, Petitioner was evaluated by Dr. Aribindi 3 or 4 times (Tr 64). Petitioner is aware that Dr. Aribindi opined that he can work in the smaller trucks and can work in the larger trucks if there was some sort of assistance in getting into the truck available to him (Tr 64). Petitioner did not disagree with those opinions (Tr 64). The parties stipulated that Petitioner was offered a truck driving job, a no touch load with a 53 foot trailer and a gate guard job on June 13, 2012 (Tr 65). Petitioner stated that before he was fired, he was driving a truck with a no touch load with a 53 foot trailer (Tr 66). Now that he has Dr. Aribindi's opinion, Petitioner possibly will look into driving smaller trucks (Tr 67). Petitioner acknowledged he can look into mechanical assistance opportunities to climb into a truck (Tr 67-68).

On re-direct examination, Petitioner testified that in his 40 years of experience, he has never seen drivers that had assistive devices get into over-the-road trucks (Tr 68). It was not his understanding that Respondent was offering him a van driving position (Tr 69). Petitioner first became aware of Respondent's job offers through his attorney and he did not talk to Mr. Tennant directly about these job offers (Tr 69). When he started working as a gate keeper, they did not tell him that they had a job working in a van (Tr 69). Petitioner guessed the pay for driving smaller trucks or vans would pay half of what an over-the-road truck driver makes (Tr 69-70). No one at Respondent offered him an assistive device for getting into an over-the-road truck (Tr 70). He has no idea what an assistive device for getting into a truck means (Tr 70). No one from Respondent offered to help him find an alternative job at maybe some different employer that would have an assistive device to get into an over-the-road truck (Tr 70). Petitioner remembered being shown Rx4, a disciplinary action dated September 22, 2010; prior to this hearing, he had never seen Rx4 and his signature is not on Rx4 (Tr 71).

If he was back in Illinois within a few days of the September 6, 2010 incident as the driving logs indicate, Petitioner did not seek medical treatment until September 21, 2010 because office manager Sandy did not make arrangements for him to do so (Tr 72). The first time

arrangements were made was when he was sent to Concentra by Sandy on September 21, 2010 (Tr 72). Petitioner had not seen the FCE report before this hearing (Tr 73). Petitioner is not currently working for Respondent because it got so that he was having to drive about a hundred miles a day working the night shift as a gate guard and he was not able to sleep during the day (Tr 74). Petitioner did tell Chris Tennant that. Chris Tennant is the cousin of the owner of Respondent who is in charge of the yard and security (Tr 74). Petitioner did tell "them" about his right shoulder treatment because he had an appointment with Dr. Gunderson the following week regarding his right shoulder (Tr 74). Petitioner told "them" that he would be available again in December for the same job because he hoped by then to be able to drive a truck again (Tr 74-75). Petitioner has no appointments set with Dr. Gunderson for his left shoulder. His next appointment with Dr. Gunderson for his right shoulder is set for September 4, 2012 (Tr 75). In order to physically get into a semi-tractor, a person has to reach up with both arms above shoulder height and pull himself up 3 step levels. There are 2 steps on the fuel tank and then another step into the cab (Tr 75-76). Petitioner guessed he weighs between 290 and 300 pounds (Tr 76).

The Arbitrator reminded Petitioner that he testified he did not want to take a job that would pay half as much as he made and at the time of the accident his average weekly wage was $881.07. The Arbitrator asked what job Petitioner did not want to take that would have been paying $440.00 a week (Tr 76). Petitioner answered that it would have to be a local job so he would not have to do a lot of driving with his vehicle. Petitioner stated he lives in Princeton, Illinois and by local he meant within a 10 to 15 mile radius, so he is not putting a lot of miles on his vehicle (Tr 77). Any local job where he could drive a straight truck. There is an oil company right there in town that has tankers and straight trucks that haul the oil (Tr 77). Petitioner did not actually apply for any specific job that made half the amount of money he used to earn (Tr 78). The van trailer is not a small van-like a passenger van and 32 cents a mile is essentially what Petitioner was paid before the accident (Tr 79-80).

On re-cross examination, Petitioner testified he did not like the gate guard job (Tr 81). It is not true that as an over-the-road truck driver that he often drove at night (Tr 81). Petitioner stated that when you haul overnight, you can't run at night, the daylight hours only (Tr 81). The job that he was doing right after he went to Concentra, Petitioner called it light duty and that was driving a semi-tractor trailer van when he went down to Missouri and back. Petitioner stated that was just a temporary job because he had another appointment coming up with Concentra and that would get him back in time for that and it was light duty with no chaining (Tr 82). Petitioner agreed that Respondent has those jobs full time available for drivers, but they already had regular drivers on them (Tr 82-83). That is a tractor with a 53 foot closed box trailer (Tr 83). "Van" is not referring to a panel van; it is referring to a 53 foot box trailer (Tr 83). Respondent has those and hauls parts for John Deere (Tr 83). The jobs that are in the trucking industry that Petitioner feels he can do would involve smaller step trucks where he could just step into them and where he would not have to climb up using his arms (Tr 83-84). Those jobs would be at half of what he was making before the accident (Tr 84). Step van work is usually an hourly rate and it is not $20 an hour, but he does not know because he has not looked into it (Tr 84).

On re-direct examination, Petitioner testified that in his 40 year career as a truck driver, he has driven a semi-tractor with a box trailer, besides the light duty he mentioned (Tr 85). Petitioner had pulled a box trailer for 6 to 8 years out of the 40, and a refrigerator truck (Tr 85). He had to pull himself up into one of those trucks as well, if he unloaded (Tr 85). Just to get in and out of the truck, he did have to pull himself up (Tr 86). He has to pull himself up into a 53 foot trailer. The 53 foot dry box van is approximately 4 feet off the ground and he has to lift himself in (Tr 86). Petitioner did not believe he was capable of lifting himself into one of those trailers (Tr 86).

2. Aaron Tennant testified he is president and CEO of Respondent (Tr 89). Respondent has been in business since 1946 (Tr 90). Respondent's business consists of hauling machinery, equipment and general commodities across the United States (Tr 90). Respondent is a family owned business (Tr 90). Respondent currently has 184 trucks. Mr. Tennant has a commercial driver's license (Tr 90). The last time he drove a semi was in July 2012 (Tr 90). Since graduating high school, he worked in the shop changing tires and washing trucks. He started driving as soon as he turned 18. When he turned 21, he was able to leave the State of Illinois and travel over-the-road. In his mid to late 20s, he came into the office and worked as a dispatcher and eventually bought the business (Tr 91). He is also very active in the trucking industry. He was past president of the Machinery Haulers Association, board of director on the Truck Load Carriers Association, board member of the Illinois Trucking Association and board member of the Iowa Motor Truck Association (Tr 91). He is very familiar with the trucking industry in the State of Illinois and generally throughout the country (Tr 91-92). He speaks all over the country on the driver shortage issue and several other truck industry matters (Tr 92). He opined that in the State of Illinois and throughout the country, trucking companies currently have a need for qualified drivers (Tr 92).

Mr. Tennant is familiar with Respondent's company handbook for drivers (Tr 92). He was shown this handbook, Rx1. Petitioner was an employee of Respondent in 2008, 2009 and 2010 (Tr 93). Petitioner received a copy of this handbook (Tr 93). On Page 3 of Rx1, Rule 3C 5 indicated that it is the driver's responsibility to keep the truck clean (Tr 94). It is his understanding that he is at the hearing because of an alleged accident Petitioner had on September 6, 2010 (Tr 94). Prior to that date, Petitioner was written up several times for abuse of equipment and cleanliness issues (Tr 94). It is Respondent's policy that if a driver is written up three times, that driver is subject to being terminated (Tr 94). Mr. Tennant became CEO of Respondent on December 21, 2009 and was so in February 2010 (Tr 95). At that time he had supervisory capacity over the drivers in a general sense (Tr 95).

Mr. Tennant was shown Rx2, a Disciplinary Action Form dated February 9, 2010, which was presented to Petitioner because when his truck was brought in, it had several bottles of urine inside the truck and it was not in the condition that he could send his mechanics into the truck (Tr 95). Petitioner was given a written warning for lack of cleanliness of the truck (Tr 96). The handbook states that drivers are to keep the truck clean (Tr 96). Respondent's attorney informed Mr. Tennant that Petitioner testified that he was urinating in the truck into bottles while he was

operating the truck (Tr 96). Mr. Tennant stated that if a driver is urinating into a bottle while he is in the tractor, that is against the rules, especially when the bottles break and urine is all over the truck cab (Tr 96).

Mr. Tennant was shown Rx3, a Disciplinary Action Form dated July 25, 2010 which was presented to Petitioner and was signed by him (Tr 96-97). The disciplinary action was regarding the interior of the truck cab, which was inspected and there were concerns with cleanliness and Petitioner was instructed to clean the truck cab out. This was the second warning (Tr 97). Mr. Tennant was shown Rx4, a Disciplinary Action Form dated September 22, 2010 that was presented to Petitioner (Tr 97). The reason for the disciplinary action was that the interior of the truck cab was inspected for cleanliness and it did not pass. There was an odor and it was filthy with garbage, food containers and pee bottles (Tr 98). Petitioner was instructed to clean out the truck cab (Tr 98). Mr. Tennant was shown Rx6, Rx7 and Rx8 and identified them as photographs of the interior of unit 426, Petitioner's assigned truck, which showed garbage all over the truck cab and the bottles of urine that are clearly visible. The photographs were taken after one of the disciplinary action forms, but he did not know which one (Tr 98).

On September 24, 2010, Mr. Tennant himself looked inside Petitioner's truck cab and the condition of it was similar to what the photographs depict. There were urine bottles all over, some of which had broken, and there was a very, very strong odor and garbage, more than the photographs depict (Tr 99). Mr. Tennant then confronted Petitioner regarding the condition of the truck cab (Tr 99). He asked Petitioner to clean out the truck cab and he refused. Mr. Tennant stated that Petitioner said he would sue the company and he walked out (Tr 100). The cab was eventually cleaned out by his mechanics who wore masks, rubber gloves and overalls (Tr 100). About $6,000 worth of interior work had to be done to the interior of the truck cab because the urine had saturated the floor mat and insulation within the floor, the mattress was gone and the seats had to be removed and replaced (Tr 100).

Mr. Tennant was shown Rx12, a Disciplinary Action Form dated September 24, 2010 pertaining to Petitioner and the circumstances on that day regarding him (Tr 101). Mr. Tennant stated that Petitioner was not fired, he walked out of the office. He never told Petitioner that he was fired. He told Petitioner to clean the truck cab and he walked out of the office (Tr 101). Mr. Tennant is aware Petitioner alleged a work accident occurring on September 6, 2010. He was not aware of it at the time of their confrontation on September 24, 2010 (Tr 102). Respondent's attorney informed Mr. Tennant that Petitioner testified that after coming from Concentra on September 21, 2010 that he was driving a van trailer of Respondent that involved no lifting and was a drive only. Mr. Tennant agreed that Petitioner was driving a van trailer. Mr. Tennant does have jobs like that at Respondent, it is a regular job and it is called a no touch load (Tr 102). For a no touch load all that is needed is to hook on to the trailer and drive down the road (Tr 103). In the fall of 2010, Respondent had no touch trucking jobs available (Tr 103). No touch trucking jobs are available now at Respondent (Tr 103). Those jobs pay more than 32 cents a mile, currently 36 cents a mile (Tr 103). The trucking industry in Illinois has opportunities available for no touch driving of semi-trucks. There are 330,000 truck driving jobs available throughout

the U.S. (Tr 104). Petitioner drove a semi-tractor trailer for Respondent between September 6, 2010 and September 24, 2010 (Tr 104). Petitioner drove on September 22, 2010 and September 23, 2010 (Tr 104). Petitioner drove right up to the point where he walked out over refusal to clean the truck he was assigned (Tr 104). Currently Respondent has a position available if Petitioner wanted it to drive a no touch semi-tractor trailer (Tr 105). Mr. Tennant also offered Petitioner a job as a gate guard if he wanted that instead. That job was the night shift and paid $15 per hour (Tr 105). At the time Petitioner was offered the night shift gate guard job, the day shift jobs for that same position were filled by other people (Tr 105). The night shift gate guard job pays $1 more an hour than the day shift gate guard job (Tr 105). It has been about a week that Petitioner has not worked the gate guard job. Mr. Tennant was informed by Petitioner's supervisor that Petitioner said he was leaving to have shoulder surgery (Tr 106).

Mr. Tennant was shown Dr. Aribindi's report dated July 13, 2012. He read the report the night before this hearing. On the bottom of Page 2, Dr. Aribindi indicated that in order to enable Petitioner to climb into a truck without difficulty, he would require an assistive device to elevate him into the truck or less steeper steps (Tr 106-107). In light of that, Mr. Tennant is willing to work with Petitioner in terms of attempting to arrange for him to return to truck driving, if it means filling another truck (Tr 107). Respondent has many empty trucks (Tr 108). There are truck driving jobs in Illinois that would involve climbing into a truck that is not so high off the ground (Tr 108). He would call these step vans and delivery vans and a commercial driver's license is needed to operate them (Tr 108). Those are UPS or FedEx vehicles (Tr 108). Those opportunities exist in the truck driving industry (Tr 108).

On cross-examination, Mr. Tennant testified that when a driver has 3 violations such as the ones Petitioner had, that driver would be subject to termination (Tr 109). The last time was the 4th time this had happened with Petitioner (Tr 110). After 3 times, Petitioner was subject to termination (Tr 110). He did not terminate Petitioner despite the fact that it was his 4th violation and that several thousand dollars were spent replacing seats, flooring, etc. (Tr 110). He did not recall terminating anyone before when they had 3 infractions (Tr 110-111). Since becoming president and CEO of Respondent, Mr. Tennant has terminated 3 employees that he can remember (Tr 111). One was a maintenance clerk for attendance issues; one was a fleet manager because he was not meeting his matrix; the 3rd was a maintenance director because she was not coming into target on budget (Tr 111). He personally has not terminated anyone for violating company policy (Tr 111). Employees have been fired for violations of the handbook (Tr 111-112). Mr. Tennant is not aware of any individuals at Respondent that have been terminated for violation of a cleanliness policy previously. The terminations were for violations of other policies in the handbook (Tr 112). All the violations are subject to the 3-strike rule. He will give them 9 or 10 strikes as he has several empty trucks open and need drivers (Tr 112). It is more economical to allow someone that is not clean to continue driving the truck than invest that $6,000 into cleaning it up so that he can put somebody else into it (Tr 113). As long as that truck is producing revenue running down the road, he is going to leave that guy in it. Mr. Tennant stated, "We're going to make every attempt possible to ask him to clean it up and ask him to be professional, but the choice I have turning down my customers for freight or letting that truck

run up and down the road and generate revenue, it's a much better decision to let the truck run." (Tr 113-114). He would intervene if an employee lets the truck get dirty and refuses to clean it and each case would be handled differently (Tr 114). There were more trucks sitting idle 2 years ago (Tr 115). In September 2010, Respondent had 160 trucks and 14 of them were unseated. Today Respondent has 184 trucks and 6 are unseated (Tr 115). The number of unseated trucks fluctuates daily. In July 2012 there were 10 unseated trucks, in June 2012 there were 11 and in February 2012 there were 21 or 22 (Tr 115). In the last 2 years all the trucks were not seated (Tr 116). To his knowledge since 1946, Respondent has never had all their trucks seated (Tr 116). He is not just willing to offer anybody work (Tr 116).

Mr. Tennant had looked in Petitioner's truck cab before their conversation on September 24, 2010 (Tr 117). Petitioner was not driving a different tractor for the few days before September 24, 2010. Petitioner was driving truck number 426, the same truck he had always driven for Respondent (Tr 117). Petitioner may have been given light duty work on a 53 foot van trailer for those 3 days, but the tractor was the same (Tr 117). Mr. Tennant stated that a person does not have to pull himself into that tractor and he grabs the grab handle at waist height (Tr 118). A person needs one arm to pull (Tr 118). A person never has to overhead pull to get into the truck (Tr 119). Mr. Tennant has never seen any of his truckers lift overhead to get into the truck (Tr 119). According to the stipulations in this case, notice of this accident was given to Rick the dispatcher (Tr 120). At that time, Respondent did have a dispatcher named Rick (Tr 120). Respondent's policy for reporting accidents: the employee reports it to his direct supervisor, who records it and sends it to the safety director (Tr 120). The dispatcher is the direct supervisor (Tr 120-121). Mr. Tennant stated that there is a note from Rick that he did not receive notice of this (Tr 121). Respondent's attorney stated that his stipulation was that Respondent received notice within 45 days of the accident (Tr 121). Mr. Tennant stated that Rick said he was not notified after the accident. Respondent's policy is that the employee notify someone at the time of the accident (Tr 121).

Mr. Tennant would not agree that Petitioner was working light duty for the 3 days prior to the September 24, 2010 conversation (Tr 122). Respondent's trucks switch out trailers all the time. A truck driver could be hauling a John Deere combine one day and a van trailer what was referring to as a no touch or light duty trailer hauling a load of Purina Dog Food the next day (Tr 122-123). Since Petitioner was hired, there were several times he had driven light duty items, but he would have to look back at the dispatch records (Tr 123). Mr. Tennant did not think Petitioner was on light duty at the time of the September 24, 2010 conversation because he had no knowledge of any injury at that time (Tr 123). Sandy was the safety director at that time (Tr 123). At this hearing, Mr. Tennant became aware that Petitioner went to a facility called Concentra on September 21, 2010 and he was not aware of that on September 24, 2010 (Tr 123). He was not aware that Petitioner was testifying that Sandy is the person who told him to go there (Tr 124). Sandy had the authority as safety director to tell Petitioner to go to that facility or any facility (Tr 124). He would have to ask Sandy if she told Petitioner to go there or not (Tr 124). He had no basis to dispute whether it is true or false (Tr 124). It is possible that someone at

Respondent, the safety director, knew that Petitioner had an injury prior to his conversation with Petitioner on September 24, 2010 (Tr 125).

It was Mr. Tennant's idea to offer Petitioner alternative work in the last couple years. Petitioner was released and he needed work and Respondent had opportunities available (Tr 126). He became aware that Petitioner was released by the case worker of the insurance carrier, who contacted the current safety director with the release (Tr 126). Mr. Tennant, the current safety director and the case worker discussed on the phone that there was a release, there were limitations and there was a security position open and it seemed like a natural fit (Tr 128). Petitioner was also offered a truck driving job. Petitioner was told to come in and get the truck and work in the van division, the machinery division, where good qualified drivers were needed (Tr 129). It is his understanding that he was offering Petitioner a full over-the-road semi-tractor trailer, a big vehicle for him to drive as long as he could get into it (Tr 129). Petitioner was offered a regular truck driving job, not a smaller van that would have smaller steps to get in (Tr 129). He did not specifically offer Petitioner prior to this day one of those trucks that has less steep steps (Tr 130). Nobody worked the night guard job prior to Petitioner as Respondent had just moved into that facility (Tr 131). 1st shift, 2nd shift and 3rd shift were all brand new positions (Tr 131). The night shift gate guard position has been posted and some temporary workers are being used currently (Tr 131). There is no difference in pay between a no touch truck driving job and a lifting truck driver job and both are 36 cents per mile (Tr 132). The pay scale is flat today with premiums for over dimensional or overnights. The more specialized the driver, there is a mileage bonus pay, the number of days out and safety performance. Cleanliness of the truck is figured into that and maintenance (Tr 132).

Mr. Tennant testified that Sandy was the only other person present during the September 24, 2010 conversation with Petitioner (Tr 132-133). Petitioner refused to sign Rx12, the Disciplinary Action Form dated September 24, 2010, as he could not be gotten a hold of (Tr 133). Rx12 was not filled out in his presence. Rx12 was filled out hours after Petitioner had left the premises (Tr 133-134). Mr. Tennant did not dispute that after Petitioner walked out of the office, he remained on the premises for 2 hours waiting for his wife to pick him up (Tr 134). During those 2 hours, Mr. Tennant did not make any attempt to go out and talk to Petitioner and he did not know if any of his staff did (Tr 134). Rx12 was filled out sometime that day (Tr 134). At that time he had no idea Petitioner was there for 2 hours after he left the office (Tr 135). When someone threatens to sue him and walks out of his office, he does not want to make a step towards that person (Tr 136). When Petitioner was released from his final restrictions, he offered him work again (Tr 136). When asked why he did not offer Petitioner work again as soon as he was out of the building or call Petitioner and tell him he still had work available to him if he wanted to come back, Mr. Tennant stated that it was not his job to do that and it was not his role and that is his recruiter's role (Tr 136). On the first 3 occasions when Petitioner was disciplined and told to clean the truck cab, Petitioner did not clean the cab. Either the first or second time, Petitioner said he cleaned the cab. The truck was inspected and all Petitioner did was push everything under the bunk. Mr. Tennant stated, "So my mechanics went in there and they flipped the bunk up to work in the bunk heater, and all that urine came out on them."

(Tr 137). Mr. Tennant did not recall if Petitioner threatened to quit or sue him after the first time he was disciplined or the second time or the third time; it was only the fourth time (Tr 137-138). It is correct that all the other times, even though he told Petitioner to do it and he did not do it, everything just went on as normal except the fourth time (Tr 138).

On re-direct examination, Mr. Tennant testified that the driving positions at Respondent where they haul the 53 foot van trailer, which involves driving but no touching the load, is lighter in terms of physical demands on a person (Tr 139). Those are regular jobs that people are doing full time (Tr 139). Petitioner went from driving a flat bed which involved securing the loads with chains, to driving with a van box trailer after he went to Concentra on September 21, 2010 (Tr 139). Driving with a van box trailer was a regular job, as opposed to a light duty job (Tr 139). That 53 foot van semi-trailer job is the same job that was essentially offered Petitioner in June 2012 (Tr 139-140). Other drivers at Respondent are doing that job now (Tr 140). It is his testimony that Petitioner walked out of the meeting on September 24, 2010 refusing to clean his truck (Tr 140). After that, Petitioner never contacted him to say he wanted to come back and drive and clean the truck and do what he had to do (Tr 140). Since Petitioner walked out threatening to sue him, there was essentially nothing left to do with respect to his status since he left of his own volition (Tr 140).

On re-cross examination, Mr. Tennant testified that the last time Petitioner stopped working the gate guard job, he did not know if anybody from Respondent asked Petitioner to fill out paperwork that said he was leaving or quitting the job (Tr 141). Respondent does not have a policy about that (Tr 141).

3. Exhibits were admitted into evidence at the May 23, 2013 arbitration hearing.

4. In the Employee Handbook, Rx1, the following is noted: III. Equipment: C: Driver Responsibilities: 5. "Cleanliness of the interior of the cab of the tractor is your responsibility."

In a Disciplinary Action dated February 9, 2010 against Petitioner, Rx2, it is noted that a driver violation was issued for misuse of equipment. The reason for the write-up was, "Tractor 426, filthy and filled with debris and bodily fluids (pictures)." This was noted as a violation of the driver handbook. It was also noted, "While discussing this driver stated, "whatever trips your fantasies." It was noted that Petitioner had been reprimanded for this offense 1 time before. The action taken was noted as termination if addressed again. It was noted that Petitioner left without signing this form.

In a Disciplinary Action dated July 25, 2010 against Petitioner, Rx3, it is noted that a driver violation was issued for truck cleanliness. The reason for the write-up was, "Job in Orion, truck was inspected on interior, concerned with cleanliness. Instructed John to clean out interior before leaving. Truck inspection at each terminal." It was noted that Petitioner had been reprimanded for this offense 1 time before. The action taken was noted as a warning. Petitioner signed this form.

5. The Dispatch Log for September 2010, Rx9, indicates that Petitioner left with a shipment of agricultural equipment on September 2, 2010 from PTC Alliance in Alliance, Ohio and delivered to John Deere Cylinder in Moline, Illinois on September 3, 2010. That same day, Petitioner left with a shipment of agricultural equipment from John Deere in East Moline, Illinois and delivered to Atlantic Tractor in Salisbury, Maryland on September 7, 2010. Petitioner left with a shipment of construction equipment on September 9, 2010 from the Port of Baltimore, Maryland and delivered to Komatsu in Peoria, Illinois on September 10, 2010. That same day, Petitioner left with a shipment of agricultural equipment from CNH Plant in Goodfield, Illinois and delivered to Ausra Equipment and Supply Company in Dowagiac, Michigan on September 13, 2010. That same day, Petitioner left with a shipment of steel from Atlas Tube in Plymouth, Michigan and delivered to CNH Plant in Goodfield, Illinois on September 14, 2010. That same day, Petitioner left with a shipment of agricultural equipment from CNH Plant in Goodfield, Illinois and delivered to Stoller International in Pontiac, Illinois. On September 15, 2010, Petitioner left with a shipment of agricultural equipment from Rockford Toolcraft in Rockford, Illinois and delivered to CNH Plant in Goodfield, Illinois that day. That same day, Petitioner left with a shipment of agricultural equipment from CNH Plant in Goodfield, Illinois and delivered to Titan Machinery in Avoca, Iowa on September 17, 2010.

6. According to the medical records from Concentra Medical Center, Px3, Rx11, Petitioner saw Dr. Dunbar on September 21, 2010 and reported he was undoing a leaver binder and had left shoulder pulling 2 weeks ago. Dr. Dunbar ordered left shoulder x-rays, which were done that day. The radiologist's impression was degenerative change of the left AC joint with inferior spurring and that this can be seen with impingement. Dr. Dunbar diagnosed left shoulder sprain and impingement. Dr. Dunbar ordered physical therapy and noted Petitioner may drive with no unloading. A Physical Therapy Evaluation was performed that day and the therapist noted Petitioner reported the accident occurrence was accurately described in Dr. Dunbar's note and this occurred approximately September 7, 2010 and since that time his pain has varied. Petitioner's chief complaint was left shoulder pain. The therapist recommended physical therapy 2 to 3 times a week for 3 weeks. Petitioner attended physical therapy on September 22, 2010.

7. The Dispatch Log indicates that Petitioner left with a shipment of agricultural equipment on September 22, 2010 from John Deere Harvester in East Moline, Illinois and delivered to Ashley Industrial Molding in Oelwein, Iowa that day. (Rx9).

In a Disciplinary Action dated September 22, 2010 against Petitioner, Rx4, it is noted that a driver violation was issued for misuse of equipment and violation of driver's handbook. The reason for the write-up was, "Driver at Moline terminal – sent Danny Goldigin to check interior of truck for cleanliness. Danny said truck stinked and was filthy – garbage – food containers and pee bottles. Jon was instructed to clean the truck interior. Jon arrived at Orion terminal and manager instructed him to clean inside of truck before leaving." No action was noted. Petitioner did not sign this form.

8. The Dispatch Log indicates that Petitioner left with a shipment on September 23, 2010 from Continental in Hampton, Iowa and delivered to CZ Outlet in Aledo, Illinois that day. (Rx9).

9. Petitioner followed-up with Dr. Dunbar at Concentra Medical Center on September 24, 2010 for a left shoulder sprain. Petitioner reported that he was much improved and was ready to go back to work on Monday September 27, 2010. Petitioner reported that the medications were very beneficial. Petitioner reported he was working light duty and was using his arm, exercising and pushing past discomfort. Petitioner reported better range of motion and better strength, although it was still painful above shoulder height, reaching and lifting. Petitioner reported he has had problems orthopedically since he was 13 years old, but mainly stemming from his right shoulder. Dr. Dunbar reviewed the x-rays which were positive for degenerative changes at the left AC joint with spurring. Dr. Dunbar's assessment was that Petitioner had done very well within a short period of time. Dr. Dunbar explained to Petitioner that he should not be in such a hurry to have full resolution. It was noted that Petitioner had impingement on examination and this was supported on his x-rays. Dr. Dunbar continued physical therapy and Petitioner was to follow-up on September 30, 2010. Petitioner attended physical therapy on September 24, 2010 and the therapist noted that Petitioner reported being 75% better. Petitioner reported he was performing light duty work where he can just open the doors. The therapist assessed that Petitioner was progressing with physical therapy. (Px3, Rx11).

10. In a Disciplinary Action dated September 24, 2010 against Petitioner, Rx8, it is noted that a driver violation was issued for misuse of equipment and violation of driver's handbook. The reason for the write-up was, "Tractor 426 needed heater repaired. Upon arrival at the shop – 2 mechanics entered truck and could not physically work in truck due to the filth and stench in truck. Told by President of the company to get some bleach and clean truck inside. Driver said he was suing the company and walked out the door." No action was noted. Petitioner did not sign this form.

Photographs of inside of the truck cab were admitted into evidence as Rx5, Rx6 and Rx7. There are no dates noted on the photographs.

11. Petitioner saw his family physician Dr. Crowe on October 1, 2010. In his office notes from that date, Px5, Dr. Crowe noted that Petitioner reported that he sustained a left shoulder injury at work on September 6, 2010. Petitioner reported that he was struggling with a bent handle on a trailer when he strained his left shoulder. On examination, Dr. Crowe found limited range of motion due to pain. Dr. Crowe's clinical impression was bursitis and tenosynovitis left bicep and supraspinatus tendon.

12. At Respondent's request, Petitioner saw Dr. Aribindi on November 5, 2010 for a §12 evaluation. In his report of that date, Rx12, Dr. Aribindi noted that Petitioner reported he had an accident at work on September 7, 2010. Petitioner reported that his left shoulder pain worsened and he went to Concentra Clinic on September 21, 2010. Dr. Aribindi noted the medical records

from that visit as well as the September 24, 2010 visit and physical therapy notes. Dr. Aribindi also noted the October 1, 2010 visit with Dr. Crowe. Petitioner reported that physical therapy for the last 4 to 5 weeks gave no significant improvement of his pain. Petitioner complained of pain over the anterior and lateral aspects of his left shoulder. On examination, Dr. Aribindi found tenderness over the anterior aspect of the left shoulder, good forward elevation and abduction with pain and a positive impingement sign. Dr. Aribindi's impression was left shoulder pain with tendonitis, impingement symptoms with likely labral pathology. Dr. Aribindi opined that Petitioner's history and medical records were consistent with his examination findings and with the injury sustained on September 7, 2010. Dr. Aribindi recommended a left shoulder MRI to evaluate labral pathology and possible rotator cuff pathology. Dr. Aribindi recommended discontinuing physical therapy. Dr. Aribindi opined that if available Petitioner could perform modified work duties with no overhead work. Dr. Aribindi noted that if the MRI showed pathology, he would recommend a left shoulder arthroscopy. After that, he would anticipate maximum medical improvement within 4 months and anticipated Petitioner returning to work at his regular job duties in 3 months.

13. In a slip dated November 24, 2010, Px4, Dr. Crowe noted, "It is recommended that John have a MRI of his left shoulder due to history of injury and pain."

Perry Memorial Hospital records, Px15, indicate Petitioner underwent a left shoulder MRI on December 2, 2010. The radiologist's impression was: 1) moderate osteoarthritic hypertrophy of the AC joint with impingement upon the underlying rotator cuff; 2) tendonitis of the rotator cuff with significant fraying of the supraspinatus tendon, which has a high grade near full thickness undersurface tear at the critical zone; 3) mild glenohumeral osteoarthritis with a small joint effusion and diffuse lateral tear.

14. According to the medical records of Dr. Gunderson, Px6, Petitioner was seen on January 4, 2011 on a referral from Dr. Crowe for evaluation of a workers' compensation injury to the left shoulder. Dr. Gunderson noted that Petitioner reported, "He injured his shoulder back in September. He has been having persistent pain and weakness with his shoulder since that time ..." Dr. Gunderson noted Petitioner had a left shoulder MRI which showed a rotator cuff tear. On examination, Dr. Gunderson found full range of motion, but Petitioner had pain past about 110° of forward elevation and about 80° abduction; Petitioner could come up further than that but it is very painful; 3/5 supraspinatus strength; 5/5 internal and external rotation strength; mild tenderness with palpation of the AC joint. Dr. Gunderson reviewed the left shoulder MRI scan and his impression was that it showed what appeared to be a tear of the supraspinatus insertion at the greater tuberosity with no obvious retraction. Dr. Gunderson's assessment was a left shoulder rotator cuff tear. Dr. Gunderson noted Petitioner already had physical therapy and injections with no relief. Dr. Gunderson noted that Petitioner wished to proceed with arthroscopic rotator cuff repair and Dr. Gunderson opined this was the best option. He was to proceed with surgery at the earliest convenience. Dr. Crowe was to perform a pre-operative examination. In a letter To Whom It May Concern dated January 4, 2011, Dr. Gunderson authorized Petitioner off work.

15. Dr. Gunderson's records, Px7, indicate Petitioner underwent a pre-operative examination on January 25, 2011. In his January 27, 2011 Operative Report, Dr. Gunderson noted his pre-operative diagnosis as a left shoulder rotator cuff tear. Dr. Gunderson performed an arthroscopic left shoulder rotator cuff repair and subacromial decompression. Dr. Gunderson's post-operative diagnosis was: 1) left shoulder vertical tear of the supraspinatus with a small tear from the tuberosity; 2) bicipital tendinosis and superior labral tear. On February 8, 2011, Dr. Gunderson noted that Petitioner had a somewhat atypical longitudinal type tear. At the tuberosity it was not a large tear, but he had a wide gap of the rotator cuff longitudinally at the rotator level. This was closed with simple sutures across the gap. Dr. Gunderson noted Petitioner was doing well now. Petitioner reported good pain control with prescribed medications. Petitioner was to begin using a CPM machine the following Monday. Petitioner saw Dr. Gunderson again on March 11, 2011, who noted that he had an atypical tear with a longitudinal component and quite a large tear. On examination, Dr. Gunderson found the incisions well healed; passive range of motion to only about 70° of forward flexion and about 60° of abduction. Dr. Gunderson noted Petitioner was doing reasonably well. Dr. Gunderson encouraged Petitioner to continue using the CPM machine until he started physical therapy, which he prescribed. Petitioner was to remain off work without any use of left arm and follow-up in 4 weeks.

16. Princeton Physical Therapy records, Px16, indicate Petitioner attended physical therapy from March 23, 2011 through April 28, 2011. On April 7, 2011, the therapist noted Petitioner reported he had fallen in his bathtub.

According to Dr. Gunderson's records, Px8, Petitioner was seen on April 8, 2011. Dr. Gunderson noted that Petitioner had been doing well with therapy. Dr. Gunderson noted, "On his last therapy evaluation on the 5th he was doing very well but he recently had a fall on the left shoulder that has increased his pain." On examination, Dr. Gunderson noted that the left shoulder was somewhat difficult to move due to pain in and around the shoulder; there was no erythema, no crepitus and no instability; there was pain with forward elevation; Petitioner had up to 90° forward elevation and 63° abduction without pain; on April 5, 2011, Petitioner was 140° forward elevation and 155° abduction and 37° external rotation. Dr. Gunderson's assessment was: "This is going to be a setback as far as his fall. His shoulder is much more inflamed and he probably has some associated bursitis and pain." Dr. Gunderson prescribed medications and continued physical therapy to maintain range of motion. Petitioner was to follow-up in 4 weeks.

Petitioner was seen in an unscheduled visit on April 29, 2011. Petitioner complained of pain with forward elevation past 85° and with abduction past 85° and pain with external rotation and abduction primarily anterior and he felt a palpable snapping sensation. X-rays were taken and Dr. Gunderson noted the humeral head was in good position with elevation; AP view showed the anchors appeared to be in good position; "However, on the scapular Y and axillary view the anterior most anchor is pulled out and is sticking out prominently above the cortical bone a few millimeters and this is likely the reason for some of the mechanical symptoms he is describing." Dr. Gunderson's assessment was a pulled out or failed anchor. Dr. Gunderson discussed with Petitioner that this was something of a failure of the fixation and could mean that

his bone was not adequately strong in the area to hold the anchor or that the repair has failed also. Dr. Gunderson noted the option of surgery to go in and try to remove this particular anchor and assess the rotator cuff repair. Dr. Gunderson noted he would proceed with surgery pending workers' compensation insurer approval.

17. At Respondent's request, Petitioner saw Dr. Aribindi on May 18, 2011 for a §12 evaluation. In his report, Dr. Aribindi noted a MRI was done on December 2, 2010 and noted the findings. Dr. Aribindi noted the January surgery and post-operative treatment. Dr. Aribindi noted, "He states that he was progressing well with physical therapy, until a month ago when he struck his left arm against the edge of a bath tub. Prior to this recent injury he had noted almost full active forward elevation and much improved pain. After the fall, he noted an increase in pain about the left shoulder as well as loss of motion about the left shoulder. He now notes pain with attempted overhead motion. He also notes some weakness about the shoulder." Dr. Aribindi noted that x-rays and MRI showed one of the anchors from the rotator cuff reconstruction pulling away from the bone and Petitioner was advised to undergo repeat left shoulder surgery. Petitioner complained of persistent left shoulder pain. On examination, Dr. Aribindi found some tenderness over the anterolateral aspect of the left shoulder; forward elevation to 90°; pain with motion about this region; external rotation of about 15° to 20° with associated pain; abduction limited to 70° to 80° with pain. Dr. Aribindi reviewed the x-rays and noted an anchor pulling away and opined this was consistent with re-tear of the rotator cuff. Dr. Aribindi noted that an MRI had revealed findings consistent with recurrent rotator cuff tear. Dr. Aribindi's impression was re-tear of rotator cuff with anchor pulling away from the bone due to a fall that was sustained one month ago when his left arm struck the edge of a bath tub. Dr. Aribindi recommended repeat left shoulder arthroscopy with removal of the anchor and repeat rotator cuff reconstruction. Dr. Aribindi anticipated maximum medical improvement 6 months post-op and anticipated return to work regular duty without restrictions in 5 to 6 months. (Rx12).

18. Dr. Gunderson's records, Px9, indicate Petitioner was not seen again until August 10, 2011. In his records of that date, Dr. Gunderson noted Petitioner's prior visit on April 29, 2011. He had been having snapping symptoms primarily in the bicipital region and anteriorly that had been giving him a lot of pain. Dr. Gunderson noted that Petitioner had been cleared by the workers' compensation carrier to proceed with revision surgery for either removal or sinking of the pin and addressing the scar tissue and possible recurrent rotator cuff tear. Dr. Gunderson noted that Petitioner was to have surgery as soon as possible. Petitioner underwent a pre-operative examination on August 22, 2011 and was cleared for surgery.

In his August 29, 2011 Operative Report, Dr. Gunderson noted his pre-operative diagnosis of failed left rotator cuff repair with prominent hardware. Dr. Gunderson performed a left shoulder arthroscopic revision and rotator cuff repair. His post-operative diagnosis was longitudinal tear of the rotator cuff internal of the left shoulder with scar formation in the subacromial space. There was no prominence of a suture anchor visible within the shoulder joint. The repair at the insertion appeared to be stable.

On September 6, 2011, Dr. Gunderson noted, "He was found to have a new longitudinal tear that was repaired with margin conversion stitches. The lateral tuberosity was found to be still well attached and intact. No evidence of prominent anchors could be identified intraoperatively." Dr. Gunderson's impression was that Petitioner was doing well. Petitioner was to continue with the CPM chair. In a slip dated September 19, 2011, Dr. Gunderson authorized Petitioner off work starting August 28, 2011 and gave restrictions of no use of his left arm. On October 4, 2011, Petitioner reported to Dr. Gunderson that he had reasonably good pain control and was using the CPM chair. On examination, Dr. Gunderson noted that the left shoulder was quite tight. Dr. Gunderson noted he was now ready for formal physical therapy and prescribed same.

19. In his October 5, 2011 deposition, Px12, Dr. Gunderson testified he is a board certified orthopedic surgeon. Dr. Gunderson recited from his records. Dr. Gunderson opined causal connection for Petitioner's first surgery (Dp 11). CPM stands for continuous passive motion machine. Dr. Gunderson's protocol is usually not going back to work until at least 3 months after surgery (Dp 15). Dr. Gunderson read his April 8, 2011 notes and noted Petitioner had a fall on his shoulder and increased pain (Dp 16). He noted that until the bathtub fall, Petitioner had been doing pretty well (Dp 17). After the fall, Petitioner was having more pain and more difficulty moving (Dp 17). Dr. Gunderson noted the second left shoulder surgery and opined causal connection for the second surgery (Dp 22). Dr. Gunderson noted that the original reason that he went back in the shoulder was he thought that the original anchor had failed, which is a known complication (Dp 22). Intraoperatively, Dr. Gunderson found a very diffuse and abundant scarring of the subacromial space, which is, he thought, a lot of the reason why Petitioner was having so much snapping and pain in his shoulder (Dp 23). Dr. Gunderson opined he would not consider the April 2011 shower fall a breaking of the causal connection chain. Dr. Gunderson opined it is all related to the original injury (Dp 23). Dr. Gunderson opined that he did not know what, if anything, the fall actually did to his shoulder after looking at it (Dp 23). Dr. Gunderson opined that he really thought the primary problem was the abundant scar tissue from the previous surgery (Dp 23). Dr. Gunderson opined that the scar tissue would have been there regardless of the fall (Dp 24). He opined that most people make an abundance of scar tissue in that area after any surgical procedure (Dp 24).

On cross-examination, Dr. Gunderson read §12 Dr. Aribindi's reports of November 5, 2010 and May 18, 2011 (Dp 28). Dr. Gunderson did not review Petitioner's medical records prior to his first visit (Dp 29). In the first surgery, Dr. Gunderson found a vertical tear between the supraspinatus and the subscapularis, the area where the biceps tendon runs through and it was an "L-shaped" tear (Dp 34-35). Dr. Gunderson opined that the bicep tendinosis was related to the injury (Dp 36-37). Dr. Gunderson noted the findings of the second surgery (Dp 39). The tear found in the second surgery was larger and in the same spot as the first tear found in the first surgery (Dp 40). The tear found in the second surgery was not a tear in the muscle itself, but the membrane between the two muscles that was open (Dp 41). The tear found in the second surgery was an extension of the tear found in the first surgery, an extension of the original finding of the longitudinal split between the two muscles (Dp 42-43). The tear was not

necessarily new, it was enlarged (Dp 43). From the time of the first surgery in January 2011 until the time of the second surgery on August 29, 2011, the longitudinal component got worse (Dp 44).

Dr. Gunderson agreed with Dr. Aribindi's opinion of November 5, 2010 that at that time Petitioner was capable of working modified work with no overhead work (Dp 45). Dr. Gunderson would not find it unusual for Petitioner to have a date of accident of September 6, 2010, but not seek treatment until September 21, 2010 (Dp 46-47). After the first surgery, Dr. Gunderson expected Petitioner's recovery to be 3 months at a minimum and a return to work at least light duty at 6 months minimally (Dp 51-52). Dr. Gunderson opined that a likely prognosis was that Petitioner would probably likely be able to return to work to truck driving (Dp 52). Petitioner was doing about as expected, maybe a little bit behind the curve, up until the beginning of April 2011 (Dp 52-53). Dr. Gunderson noted Petitioner sustained a fall in April 2011. When Petitioner was first seen after the fall, he was having increased pain and his general examination findings were worse (Dp 53). Dr. Gunderson opined that after the fall, Petitioner was subjectively and medically objectively worse (Dp 53-54). Dr. Gunderson did not know the mechanics of the fall (Dp 54). Dr. Gunderson read in Dr. Aribindi's May 18, 2011 report a history of Petitioner striking his left arm against the edge of a bathtub and it could have been a direct blow to the left shoulder (Dp 54-55). Dr. Gunderson recommended a repeat surgery after x-rays showed that an anchor was prominent (Dp 55). That was not the actual finding intraoperatively (Dp 56).

Dr. Gunderson testified that the increased pain complaints were noted right after the fall (Dp 57). It is somewhat fair to say that what started the ball rolling on getting the second surgery was the bathtub fall (Dp 59). Dr. Gunderson opined that if Petitioner had not had the fall, he may have had an uncomplicated recovery and just gotten better and better (Dp 59). It was possibly fair to say that if the bathtub fall had never happened, he may have been able to proceed and never have had a second surgery (Dp 59). Dr. Gunderson does not get x-rays routinely and he ordered x-rays in response to Petitioner's increased complaints after the bathtub fall (Dp 60). On x-ray it looked like one of the anchors was prominent (Dp 61). The second surgery was approved in June 2011, but not done until August 29, 2011. The reason for the delay was Dr. Gunderson had boards in July 2011 and August 29, 2011 was the earliest time available (Dp 62-63). In his Operative Report, it mistakenly states that Petitioner had increased pain without any specific trauma; Petitioner did have specific trauma of the bathtub fall (Dp 63). Dr. Gunderson could not say and did not know that the need to suture the muscles closer together was the result of the fall in April 2011 (Dp 66). Dr. Gunderson could not say with certainty that what he fixed in the second surgery was either a natural consequence of the initial injury or whether it was the result of the intervening fall in April 2011 (Dp 67). Dr. Gunderson opined that after the second surgery, Petitioner is much more likely to have diminished outcome as far as his ultimate range of motion and return of strength (Dp 68). Dr. Gunderson would have some doubts in light of the second surgery that Petitioner would be able to get back to the same kind of work he did before (Dp 69). Petitioner might be able to do strictly driving a truck (Dp 69). Most commonly just having surgery causes scar tissue (Dp 72). Petitioner had exceptionally thick scar tissue bands

throughout the area of his shoulder (Dp 72). Dr. Gunderson opined Petitioner is more likely to have more scarring because he has undergone 2 surgeries (Dp 72).

On re-direct examination, Petitioner testified that scar tissue was present regardless of Petitioner's bathtub fall. One of the reasons for the second surgery was scar tissue (Dp 73-74). Dr. Gunderson opined that the scar tissue found in the second surgery was a direct result of the first surgery (Dp 74). In the second surgery, Dr. Gunderson did not find a failed rotator cuff repair (Dp 77). The pain, snapping and catching Petitioner described is more consistent with scarring (Dp 77). Dr. Gunderson went in for the anchor; he would not initially have done a surgery just for scar tissue (Dp 77).

20. According to Princeton Physical Therapy records, Petitioner attended physical therapy again from October 12, 2011 through December 12, 2011. (Px16).

21. On November 1, 2011, Petitioner reported to Dr. Gunderson that he had been doing well, but recently developing more anterior pain and stiffness again and he felt like it was catching. On examination, Dr. Gunderson found there was a palpable thickened area anteriorly that was very painful to touch. Otherwise, range of motion was fairly good in abduction, but in forward elevation he had limited range to about 85° with palpable catch and exquisite pain. Petitioner was to continue physical therapy. Dr. Gunderson injected the anterior aspect of left shoulder. (Px9).

22. In an Addendum Report dated November 15, 2011, Rx12, Dr. Aribindi noted that he reviewed that August 29, 2011 Operative Report and Dr. Gunderson's deposition. Dr. Aribindi noted that during surgery, Dr. Gunderson found Petitioner had a thickened bursa and what appeared to be a tear in the rotator cuff interval, which was repaired. The previous rotator cuff reconstruction was noted to be stable. Dr. Aribindi opined that Petitioner was noted to be progressing well until he injured himself in his bathroom. He was improving with his left shoulder pain and motion prior to this event. Petitioner appeared to be progressing well after the August 29, 2011 surgery. Dr. Aribindi opined that the August 29, 2011 surgery was due to the pain that he noted after the bathtub fall and not related to the original left shoulder surgery.

23. In his December 9, 2011 deposition, Rx14, Dr. Aribindi testified he is a board certified orthopedic surgeon. Dr. Aribindi recited from his reports. When he examined Petitioner on November 5, 2010, Dr. Aribindi felt Petitioner was capable of performing modified work duties, no overhead work and limited lifting of 15 to 20 pounds (Dp 11). Dr. Aribindi opined that from the date of accident September 6, 2010 until the date of first surgery in January 2011, Petitioner was capable of working the above modifying duty (Dp 12). Dr. Aribindi opined it was appropriate for Petitioner to have the January 2011 surgery (Dp 15). Petitioner was recovering well from his first surgery until the time he fell in the bathtub (Dp 15). Dr. Aribindi opined that if the bathtub fall had not occurred, Petitioner would have reached maximum medical improvement in 3 to 4 months post-op (Dp 15). Dr. Aribindi opined that but for the bathtub fall,

Petitioner would have been able to return to full duty as a truck driver after the January 2011 surgery (Dp 15-16).

Following the January 2011 surgery, Petitioner had almost full active forward elevation that he was able to raise his left arm to the overhead position completely by himself and he reported much improved pain at that time (Dp 16). Dr. Aribindi opined that the need for the second surgery was related to the fall in the bathtub (Dp 17). Dr. Aribindi noted the Operative Report findings of the second surgery. Dr. Aribindi opined that scar tissue is typically present after every surgery to the shoulder joint (Dp 18). Dr. Aribindi opined that the interval tear that was repaired by Dr. Gunderson was not necessary to repair (Dp 19). Dr. Aribindi opined scar tissue can be aggravated by a traumatic blow (Dp 20). Dr. Aribindi opined that more likely than not, the bathtub fall aggravated the scar tissue in the shoulder joint resulting in pain (Dp 20). Dr. Aribindi opined that it would be a very fair statement to say that the reason for the second surgery is because Petitioner fell on the left shoulder in the bathtub (Dp 21). Dr. Aribindi opined Petitioner should be at maximum medical improvement and able to return to his regular work duties as a truck driver (Dp 22).

On cross-examination, Dr. Aribindi testified that if the anchor had been dislodged, this could show that the construction from the first surgery had failed (Dp 26). Dr. Aribindi opined that the first surgery was reasonable and necessary, given the circumstances. Dr. Aribindi opined that the second surgery was also reasonable and necessary, given the circumstances. Dr. Aribindi opined that at the time Petitioner fell in his bathtub, he was pretty close to maximum medical improvement (Dp 27). Dr. Aribindi opined that Petitioner's left arm was in a weakened state at the time of the fall (Dp 28). The second surgery was done because he had pain in the shoulder after the fall (Dp 28). He could not say for sure that Petitioner's pain at that time was related to scar tissue (Dp 29). The scar tissue was related to the first surgery (Dp 29). If it was just for the scar tissue, Dr. Aribindi did not think Dr. Gunderson would have gone in to do the second surgery (Dp 31).

On re-direct examination, Dr. Aribindi testified that according to the Operative Report for the second surgery, the anchors from the prior surgery were not dislodged and the rotator cuff reconstruction was stable (Dp 42). The only findings Dr. Gunderson found during surgery were a rotator interval tear which he thought he should fix while he was there and thickened bursal tissue or scar tissue (Dp 42). Dr. Aribindi opined that Petitioner could have had the second surgery even if the first surgery had never happened (Dp 43). There can be scar tissue from a fall and just wear and tear over the years (Dp 43).

24. Petitioner saw Dr. Gunderson on January 4, 2012 and reported he was actually doing better. His range of motion was improved substantially since his last visit, although he still had pain in the anterior part of his shoulder where his primary scar tissue had been. On examination, Dr. Gunderson found that the scar tissue anteriorly seemed to be a little more supple and pliable; forward elevation was to 175° and 140° of abduction, 80° of external rotation, full internal rotation; rotator cuff strength is 4+/5. Dr. Gunderson's impression was that Petitioner still had a

lot of anterior pain that was likely due to the exuberant scar tissue in the anterior aspect of the shoulder. Petitioner was to continue working on range of motion. Dr. Gunderson opined, "I do believe he will probably have chronically weakened shoulder overall and some degree of less functionality because of pain inhibition in his shoulder." In a slip dated January 10, 2012, Dr. Gunderson continued Petitioner off work. In a letter to Petitioner dated January 18, 2012, Dr. Gunderson approved weight strengthening exercises at the Princeton Metro Center. Petitioner was to start slow and gradually increase. (Px9).

25. Petitioner attended a functional capacity evaluation on April 16, 2012. In the FCE report, Px2, Rx10, the therapist noted Petitioner's diagnosis of left rotator cuff repair. Petitioner demonstrated material handling abilities of bilateral lifting up to 65 pounds, bilateral carrying up to 65 pounds and bilateral shoulder lifting of 55 pounds. Pushing and pulling were up to 84 horizontal force pounds. The therapist opined that the overall results represented a true and accurate representation of Petitioner's overall physical capabilities and tolerances at that time. Petitioner demonstrated the ability to perform 81.9% of the physical demands of his job as truck driver. The Return To Work test items that Petitioner was unable to perform included occasional shoulder lifting, occasional overhead lifting, occasional pushing, occasional pulling, above the shoulder reaching, ladder/other and work simulation. The therapist opined consistent performance secondary to the maximum effort was demonstrated by Petitioner. The therapist opined that Petitioner demonstrated the ability to perform at the Medium-Heavy physical demand level. Petitioner's truck driver job is classified within the Heavy physical demand level.

26. Dr. Gunderson's records, Px10, indicate Petitioner was seen on May 15, 2012 and he reviewed the FCE report. Dr. Gunderson noted that the functional capacity evaluation confirmed Petitioner's limitation of lifting heavy objects and anything overhead. Dr. Gunderson opined Petitioner was at maximum medical improvement and would not benefit from further therapy. Petitioner was to continue home exercises. Dr. Gunderson opined that the pain Petitioner was experiencing was not an indication for a future total shoulder replacement. Petitioner's pain was primarily provoked with overhead and shoulder level heavy lifting. At rest he was comfortable. Dr. Gunderson opined that a total shoulder replacement would not make him any more able to return to his previous occupation. Dr. Gunderson discontinued physical therapy.

27. In a letter to Petitioner's attorney dated June 19, 2012, Px11, Dr. Gunderson noted that Petitioner was unable to engage in any sort of heavy lifting activities. Dr. Gunderson noted, "He has historically worked as a truck driver and the major issue impeding his ability to work as a truck driver would be his ability to get in and out of the truck well and independently without causing pain...Lifting his body weight up into a truck using his arm is something that given his functional capacity evaluation and my clinical evaluation of Mr. Winters, I do not believe he would be able to participate in that kind of activity. Therefore, that would be out of his realm of his functional capacity."

28. In a Job Offer confirmation letter dated June 21, 2012, Rx15, it was noted that Petitioner was offered 2 jobs on June 13, 2012. The first job was a gate guard working the 3rd shift paying $15 per hour. The second job was truck driving only involving no lifting paying 32 cents per mile with at least 2,500 miles per week ($800).

29. At Respondent's request, Petitioner saw Dr. Aribindi on July 13, 2012 for a §12 evaluation. In his report of that date, Rx12, Dr. Aribindi noted that Petitioner reported the pain about his left shoulder improved following post-operative physical therapy. Petitioner continued to note pain over the anterior aspect of the left shoulder with overhead motion and overhead activities. Petitioner reported he is unable to return to his regular work activities as a truck driver because of his inability to climb into a truck. Dr. Aribindi noted the April 16, 2012 FCE findings. Dr. Aribindi Petitioner was currently working as a gate guard. Petitioner reported he can drive a truck, but not get into a truck because of pain and weakness in his left upper extremity in the overhead position. On examination, Dr. Aribindi found active forward elevation of 140° to 150°; active abduction of 90° to 100°; external rotation of about 20° to 25°; adduction/internal rotation to the belt line; mild tenderness over the anterior aspect of the left shoulder; shoulder strength in forward elevation and abduction at 4+/5. Dr. Aribindi's impression was improved left shoulder pain, motion and strength following arthroscopy with rotator cuff reconstruction. Dr. Aribindi opined Petitioner was at maximum medical improvement. Dr. Aribindi opined, "As noted by the functional capacity evaluation and consistent with today's examination, Mr. Winters is unable to climb into a truck without assistance due to pain and weakness in his left shoulder as well as his large size. He can safely drive a truck once he is in it. To enable him to climb into a truck without difficulty, he would require an assist device to elevate him into the truck or less steeper steps." Dr. Aribindi opined Petitioner did not require any further medical treatment. Dr. Aribindi opined did not envision Petitioner requiring any further left shoulder surgery.

30. Petitioner submitted his final paystub from Respondent dated August 24, 2012 and this was admitted into evidence as Px17.

31. Petitioner submitted medical bills which were admitted into evidence as Px1. The following medical bills were for services related to the second left shoulder surgery performed on August 29, 2011:
-Katherine Shaw Bethea Hospital D/S 8-29-11: Charges: $29,593.69. Payment by workers' compensation insurer: $16,913.69. Adjustment: $12,680.00. Balance due: $0.
-Katherine Shaw Bethea Hospital D/S 1-4-12 Dr. Gunderson visit: Charges: $95.00. Payment by workers' compensation insurer: $37.57. Adjustment: $57.43. Balance due: $0.
-Katherine Shaw Bethea Hospital D/S 2-15-12 Dr. Gunderson visit: Charges: $78.00. Payment by workers' compensation insurer: $26.62. Adjustment: $51.38. Balance due: $0.
-KSB Medical Group, Dr. Gunderson D/S 8-22-11: Charges: $71.00. Payment by workers' compensation insurer: $47.76. Adjustment: $23.24. Balance due: $0.
-KSB Medical Group, Dr. Gunderson D/S 8-29-11: Charges: $11,494.00. Payment by workers' compensation insurer: $2,222.84. Adjustment: $9,271.16. Balance due: $0.

-KSB Medical Group, Dr. Gunderson D/S 8-29-11: Charges: $1,200.00. Payment by workers' compensation insurer: $1,200.00. Balance due: $0.
-KSB Medical Group, Dr. Gunderson D/S 11-1-11: Charges: $412.00. No payment made. Balance due: $412.00.
The total balance due is $412.00.

Pursuant to Circuit Court remand, the Commission finds Petitioner was temporarily totally disabled for an additional period from August 29, 2011, the date of the second left shoulder surgery, through May 15, 2012, the date Dr. Gunderson found Petitioner to be at maximum medical improvement, 37-2/7 weeks at $587.38 per week.

The Commission also corrects a clerical error in the first period of temporary total disability. The Commission notes that the first left shoulder surgery was performed on January 27, 2011, not January 22, 2011 as noted by the Arbitrator. Therefore, Petitioner was temporarily totally disabled from January 27, 2011 through May 22, 2011, a period of 16-4/7 weeks, and the Commission makes this correction.

The Commission further finds that the second left shoulder surgery rendered to Petitioner was reasonable, necessary and causally related to Petitioner's condition of ill-being, based on the medical records, and that Respondent is liable for such treatment. The Commission finds that the only unpaid medical expense related to the second left shoulder surgery was for KSB Medical Group, Dr. Gunderson's date of service of November 1, 2011 for $412.00. No payment was made on this bill and the Commission awards $412.00 subject to the Medical Fee Schedule.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $587.38 per week for a period of 53-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $528.64 per week for a period of 58.75 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the permanent disability of the person as a whole to the extent of 11.75%.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner all reasonable and necessary medical expenses through April 8, 2011 and $412.00 under §8(a) of the Act, subject to the Medical Fee Schedule under §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to a credit in the amount of $1,123.79 under §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall have credit for all amounts paid, if any, to or on behalf of the Petitioner on account of said accidental injury. The Commission notes that Respondent paid $35,410.20 in TTD benefits.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $26,700.00. 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.

DATED: AUG 18 2015
MB/maw
o07/16/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia A. Grass,

Petitioner,

vs. NO: 10 WC 46901

Maine Township,

15IWCC0632

Respondent.

DECISION AND OPINION ON REVIEW

This matter comes before the Commission on Petitioner's Petition for Review of the Order of Arbitrator Carlson denying reinstatement of the case. After due consideration, the Commission denies Petitioner's Petition for Review finding that it was untimely filed and therefore lacks jurisdiction and the Order of Arbitrator Carlson denying reinstatement of the case is final for the reasons set forth below.

1. On December 7, 2010, Petitioner filed an Application for Adjustment of Claim which listed a Date of Accident of March 5, 2010 and alleged a low back injury while lifting boxes. Petitioner's attorney was noted as Vincent Wagner of the law firm Pomper & Goodman. The case was assigned to Arbitrator Cronin.

2. A Notice of Case Dismissal dated March 13, 2014 indicated that the case had been dismissed by Arbitrator Carlson on February 6, 2014. The Notice indicated that unless a Petition to Reinstate was filed within 60 days of the receipt of this Notice, the case could not be reopened. The Notice of Case Dismissal was sent to the parties.

3. On April 9, 2014, Petitioner's attorney, James Richards of the law firm Pomper & Goodman, filed a Motion to Reinstate the Case. In its Motion to Reinstate, Petitioner's attorney indicated that it was his understanding that the case was set for pretrial before Arbitrator Cronin on February 5, 2014, as reflected in his master diary and a January 23, 2014 letter to Petitioner. Petitioner's attorney also indicated that on March 19, 2014, Petitioner's attorney's clerk obtained a date setting trial for April 14, 2014. The Motion to Reinstate was set for hearing on May 13, 2014.

4. On May 13, 2014, Arbitrator Carlson denied the Motion to Reinstate. No record of the May 13, 2014 hearing was made. There was no written Order in the Commission file, however, the mainframe computer system indicates that hearing was held on the Motion to Reinstate on May 13, 2014 and that Arbitrator Carlson had denied same.

5. On July 11, 2014, Petitioner's attorney, Caroline Watson of the law firm Pomper & Goodman, filed a Petition for Review of Arbitrator Carlson's Order denying the Motion to Reinstate. In its Petition for Review, Petitioner's attorney indicated that the Notice of Case Dismissal was received on March 19, 2014. Petitioner's attorney indicated that due to a docketing oversight, the date of hearing of May 13, 2014 was missed. Petitioner's attorney indicated that the Motion to Reinstate was denied presumably due to Pomper & Goodman's failure to appear and argue its Motion to Reinstate, that the failure to appear was inadvertent and not meant for delay or to prejudice Respondent, that Petitioner's claim was meritorious and requested reinstatement of the case.

In her Statement of Exceptions, Petitioner's attorney noted that there was some sort of mix-up where Petitioner's attorney's records indicated a February 5, 2014 date for pretrial. Subsequently, Petitioner's attorney discovered that the pretrial was scheduled for February 6, 2014, not February 5, 2014. Because Petitioner's attorney did not appear on February 6, 2014, the case was dismissed on that date. A Petition/Motion to Reinstate was filed on April 9, 2014 for a hearing date of May 13, 2014. Petitioner's attorney indicated that the attorney that handled Petitioner's appearances before the IWCC abruptly left the firm and the matter did not get docketed. On May 13, 2014, the Motion to Reinstate was denied, presumably due to failure to appear and argue the Motion. Petitioner's attorney indicated that a new attorney was hired by the firm and she learned of the dismissal after the time for reinstatement passed. The Commission notes that the Motion to Reinstate was filed on April 9, 2014, well within the 60 day requirement set forth in Rule 7020.90, and the date of Notice of Case Dismissal was March 13, 2014. Petitioner's attorney argued that the failure to appear at the May 13, 2014 hearing on the Motion to Reinstate was inadvertent and due to the exit of the assigned attorney and failure to docket the matter.

In his Statement of Exceptions, Respondent's attorney argued that Petitioner's attorney first failed to appear when the matter was initially dismissed on February 6, 2014. Respondent's attorney argued that Petitioner's attorney again failed to appear on the date Petitioner's Motion to Reinstate was scheduled for hearing on May 13, 2014.

15IWCC0632

The Commission finds that it lacks jurisdiction to review Arbitrator Carlson's Order denying the Motion to Reinstate on May 13, 2014. A moving party has 30 days in which to file a Petition for Review from the receipt of an Arbitrator's Decision/Order. Here, Arbitrator Carlson denied the Motion to Reinstate on May 13, 2014 and a Petition for Review was not filed until July 11, 2014. Petitioner's attorney provided no evidence as to when Arbitrator Carlson's Order was received. The Commission finds that Arbitrator Carlson's Order would have been received within a reasonable amount of time after it was issued on May 13, 2014. From May 13, 2014 to July 11, 2014 is 60 days. The Commission finds that Petitioner's Petition for Review was untimely filed and therefore, the Commission lacks jurisdiction. Arbitrator Carlson's Order denying reinstatement of the case is therefore final and the Commission affirms same.

IT IS THEREFORE ORDERED BY THE COMMISSION that the May 13, 2014 Order of Arbitrator Carlson denying reinstatement of the case is hereby final and affirmed.

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

DATED: AUG 18 2015
MB/maw
o07/30/15
43

Mario Basurto

Stephen J. Mathis

David L. Gore

STATE OF ILLINOIS)
) SS.
COUNTY OF)
WILLIAMSON

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DAVID CARTER,

Petitioner,

vs. NO: 10 WC 14575

MIDAS CARBONDALE,

15IWCC0633

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, medical expenses and prospective medical treatment, and being advised of the facts and law, reverses the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Arbitrator found that Petitioner's current condition of ill being that Dr. Appleman diagnosed and treated was not causally connected to his work-related accident. The Arbitrator further did not award medical expenses related to treatment with Dr. Appleman or prospective medical treatment. The Arbitrator awarded temporary total disability benefits, partial medical expenses and permanent partial disability benefits.

The Commission reverses the Arbitrator in part. We find Petitioner proved his current condition is causally connected to his work-related injury. Therefore, we award Petitioner all outstanding medical expenses and prospective medical treatment.

Petitioner, an 18-year-old without any history of foot complaints, sustained a crush injury

15IWCC0633

to both feet resulting in continuing neurogenic symptoms, pain and altered weightbearing. It is undisputed that Petitioner was asymptomatic in his feet prior to the crush injury on November 24, 2009. He had no prior treatment to his feet, worked full duty and was able to ride a motorcycle, drive a manual transmission truck, climb ladders and walk up stairs without difficulty. Petitioner injured his toes and the top part of his feet when the lift crushed them. From the time of the accident throughout the course of his medical treatment, Petitioner consistently presented with continuing pain and neurologic complaints. When Dr. Davis released Petitioner at maximum medical improvement, he agreed Petitioner would require ongoing care.

Dr. Appleman then began treating Petitioner for his ongoing midfoot complaints. Dr. Appleman provided Petitioner with orthotics and treatment to stabilize his midfoot. Dr. Appleman explained that Petitioner has a high arched foot and a tremendous amount of play in the first metatarsals from his big toe because of the crush injury, which translates into symptoms at the second metatarsal, where Petitioner had pain. To help control his pain, Dr. Appleman had to stabilize the entire midfoot so Petitioner could continue to ambulate on the area causing minimal to no symptoms. Petitioner's orthotics were specifically designed to help control his pain in the big toe joint, which was a direct result of the crush injury at work.

While Dr. Appleman conceded it was possible Petitioner might have had symptoms from his high arches absent the work injury, Dr. Appleman explained he believes Petitioner had compensated his ambulation and weight bearing with regard to the injury such that it never fully healed. He testified that when one breaks a toe, the body does not want to walk on it, so one starts shifting the weight around causing the other areas of the foot to become aggravated. The orthotic Petitioner was prescribed was designed to help distribute his weight throughout the whole foot to minimize the stresses on the foot where Petitioner had been placing his weight after the work injury. Petitioner had been significantly compensating on his foot so that it never stabilized from the work accident. When considering Dr. Appleman's testimony, the relationship between the work accident and orthotic treatment he provided becomes clear and supported by the medical records in evidence.

Even Respondent's Section 12 examining physician, Dr. Schafer, agreed these symptoms could continue and that patients with this type of foot injury compensate for their symptoms in the way they stand or bear weight. He also agreed that orthotics can be an appropriate form of treatment. Dr. Schafer further conceded symptoms from a nerve injury can continue and the symptoms Petitioner described are consistent with his injury and might never resolve. In conclusion, the treatment rendered by Dr. Appleman is causally connected to Petitioner's work accident.

The Commission finds Petitioner met his burden of proof showing that his current condition of ill being is causally connected to his work injury. Additionally, we award Petitioner all of his outstanding medical expenses and prospective medical treatment.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is reversed in part as stated herein.

15IWCC0633

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $245.29 per week for a period of 7-6/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $220.76 per week for a period of 50.1 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 20% loss of the right foot and 10% loss of the left foot.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $5,835.05 for medical expenses under §8(a) of the Act and Respondent shall pay prospective medical treatment as prescribed by Dr. Appleman.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $18,900.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 18 2015
TJT: kgg
R: 6/23/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

CARTER, DAVID
Employee/Petitioner

Case# **10WC014575**

MIDAS CARBONDALE
Employer/Respondent

15IWCC0633

On 8/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

5341 BROWN & BROWN LLP
RICHARD E SALMI
5440 N ILLINOIS SUITE 101
FAIRVIEW HEIGHT, IL 62208

2250 LAW OFFICE OF STEPHEN H LARSON
BRUCE J MAGNUSON
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

15IWCC0633

STATE OF ILLINOIS)
)SS.
COUNTY OF **Williamson**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

David Carter
Employee/Petitioner

v.

Midas Carbondale
Employer/Respondent

Case # **10** WC **14575**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 24, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,132.28** the average weekly wage was $**367.94**.

On the date of accident, Petitioner was **18** 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 $**1,927.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,927.27**.

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

ORDER

Credits

Respondent shall be given a credit of $**1,927.27** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**1,927.27**.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**245.29**/week for **7 6/7** weeks, commencing **11/25/09** through **1/19/10**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**1,927.27** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**4,926.24**, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $**220.76**/week for **50.1** weeks, because the injuries sustained caused the **20%** loss of the **right foot and 10% loss of the left foot,** as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

8/13/14
Date

AUG 25 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CARTER, DAVID
Employee/Petitioner

Case# 10WC014575

15IWCC0633

MIDAS CARBONDALE
Employer/Respondent

On 6/30/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

BROWN & BROWN
RICHARD E SALMI
5440 N ILLINOIS SUITE 101
FAIRVIEW HEIGHT, IL 62208

2250 LAW OFFICE OF STEPHEN H LARSON
BRUCE J MAGNUSON
940 W PORT PLZ SUITE 208
ST LOUIS, MO 63146

15IWCC0633

STATE OF ILLINOIS)
)SS.
COUNTY OF **Williamson**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

David Carter
Employee/Petitioner

v.

Midas Carbondale
Employer/Respondent

Case # **10** WC **14575**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Herrin**, on **May 15, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 24, 2009**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,132.28** the average weekly wage was $**367.94**.

On the date of accident, Petitioner was **18** 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 $**1,927.27** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,927.27**.

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

ORDER

Credits

Respondent shall be given a credit of $**1,927.27** for TTD, $**0** for TPD, and $**0** for maintenance benefits, for a total credit of $**1,927.27**.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $**245.29**/week for **7 6/7** weeks, commencing **11/25/09** through **1/19/10**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**1,927.27** for temporary total disability benefits that have been paid.

Medical benefits

Respondent shall pay reasonable and necessary medical services of $**4,926.24**, as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule injury

Respondent shall pay Petitioner permanent partial disability benefits of $**220.76**/week for **33.4** weeks, because the injuries sustained caused the **20%** loss of the **right foot and 10% loss of the left foot,** as provided in Section 8(e) of the Act.

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

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

Earl Lee
Signature of Arbitrator

6/27/14
Date

THE ARBITRATOR FINDS THE FOLLOWING FACTS

The Petitioner was employed on November 24, 2009 as a mechanic working for the Midas location in Carbondale. He had commenced the job approximately six months earlier. This was the Petitioner's first job following his graduation from high school.

The Petitioner testified that his duties included everything automotive involving changing oil, repairing brakes, and dealing with tires. He testified that he was on his feet all day. He would have to lift and carry wheels, tires, auto parts and shop supplies.

The Petitioner testified at Arbitration that on November 24, 2009 he had been doing a brake job and his feet were under the lift. He testified that his manager then lowered the lift onto both of his feet. The Petitioner noted that when the lift came down on his feet it struck his big toe and the area halfway up the top side of his feet. He let out a shout and the manger raised the lift quickly. This incident took place at the very end of the work shift.

The Petitioner left the shop and rode his motorcycle home. He claimed that he went to the emergency room but did not stay for treatment as he was told that he did not have insurance. The Petitioner noted that he had no prior problems with his feet.

The Petitioner testified that following the incident he felt horrible pain in his feet along with tingling and numbness.

The Petitioner came to work the next day and spoke with his manager. He testified that shortly after arriving at work on November 25, 2009, the manager told him to get medical attention for his feet. He therefore sought care at WorkCare Occupational Health in Herrin.

The records from WorkCare show that the Petitioner complained of pronounced pain and swelling to the distal medial right and left feet around the proximal base of the great toes. The report also records complaints of numbness to the dorsal distal right foot and the proximal base of the right great toe. X-rays were taken, which revealed that the right foot was normal. The x-rays on the left foot revealed a fracture of the base of the distal phalanx of the great toe. The final diagnosis for the Petitioner was crush injuries to both feet with undisplaced fracture of the proximal base of the left great toe distal phalanx and neuropraxia to portions of the distal right foot and right great toe. The Petitioner was placed on restricted work and referred to Dr. J.T. Davis at the Southern Illinois Orthopedic Center. (Pet.Ex.2)

The Petitioner first consulted with Dr. J.T. Davis on November 27, 2009. At that time his chief complaint was that of bilateral foot pain. The doctor noted that the petitioner complained of persistent pain located predominantly over the great toes of both feet. The Petitioner described the pain as sharp and throbbing in nature with some associated numbness and tingling in the region. Physical examination showed some tenderness, swelling and dysthesias over both great toes. There was ecchymosis greater on the left versus the right toe. Dr. Davis found tenderness to palpation extending from the MTP joint distally in both feet. There was no focal

tenderness proximal to this. Otherwise, Dr. Davis found the Petitioner's feet to be neurovascularly intact.

Dr. Davis also reviewed x-rays and described a fracture of the distal phalanx of the left great toe. Dr. Davis assessed the Petitioner as suffering from a bilateral great toe injury including a distal phalanx fracture to the great toe. He was placed in a post-op shoe and advised regarding protective body mechanics. Dr. Davis allowed him to return to sedentary work and told him to follow up in three weeks. (Pet.Ex.3)

Dr. Davis next examined the Petitioner on December 8, 2009. At that time the Petitioner reported that he was still sore especially if he bumped or put any pressure on the left great toe. The right foot was noted to be improving. The report notes the Petitioner had a little numbness over the dorsal aspect of the MTP joint and the right great toe but overall the right foot was improving.

Physical examination on this day revealed the Petitioner to be neurovascularly intact with the exception of a dime sized area over the MTP joint of the right great toe with decreased sensation to light touch. Dr. Davis also found some minor tenderness non-focally over the proximal phalanx of the right great toe. There was no tenderness over the metatarsals, remaining toes or hind foot. The Petitioner's ankle was found to be non-tender with good motion. Examination of the left lower extremity revealed the skin to be intact with some focal tenderness to palpation over the proximal aspect of the distal phalanx of the left great toe. There was no tenderness over the metatarsals, remaining toes or ankle. The left ankle showed good motion. The Homans' Sign was negative bilaterally and there was no sign of deep vein thrombosis. X-rays were taken once again which showed a well aligned fracture of the base of the distal phalanx of the left great toe. There was no evidence of fracture or dislocation to the right great foot or toe. Bilateral weight bearing AP view showed good alignment of the Lisfranc joint. Dr. Davis' assessment on 12/8/09 was that the Petitioner had a bilateral foot injury with a right great toe contusion and superficial nerve contusion with left base of the distal phalanx fracture in the left great toe. With regard to the right foot, Dr. Davis felt the Petitioner could begin progressing to activities as tolerated and weaning himself out of the post-operative shoe and back into regular footwear. With regard to the left foot, Dr. Davis felt the Petitioner needed to have a little more protection and was told to continue with the post-operative shoe. He was again released to sedentary work duties. (Pet.Ex.3).

The Petitioner returned to Dr. Davis on December 22, 2009. At that time the report records that the Petitioner reported his right foot was much improved. He was still complaining of some discomfort in the left great toe. Upon physical examination, Dr. Davis found that the right foot was non-tender to palpation over any distribution, particularly over the great toe region. There was still some decreased sensation of a dime sized area over the MTP joint of the right toe as previously described. Otherwise, there was no tenderness over any structures of the right foot or ankle and good motion was shown as well. With regard to the left foot, the doctor found no significant swelling. There was some minimal tenderness to palpation over the distal phalanx of the left great toe. Dr. Davis found the left foot to be neurovascularly intact. He found no tenderness over the middle aspect of the foot, the base of the fifth metatarsal or left ankle. Again, Homans' Sign was negative bilaterally and there was no sign of deep vein thrombosis.

The left lower extremity was again noted to be neurovascularly intact. Updated x-rays were taken. These showed good alignment of the Lisfranc joint. The fracture at the base of the left great toe was found to be stable appearing. There was no evidence of fracture in the right foot and no dislocation. Dr. Davis' assessment on this date was that the Petitioner was improving clinically with regard to his left distal phalanx fracture in the great toe. He also felt he was improving clinically regarding the right great toe contusion and the superficial nerve contusion. The report notes that the Petitioner was much improved. He was told to begin progressing out of the post-op shoe on the right foot. He was told to wear the post-op shoe on the left foot for another week and then transition back into normal footwear. The doctor anticipated releasing him for work two weeks from that date. His return to work was anticipated to be without problem. (Pet.Ex.3)

The Petitioner returned to Dr. Davis on February 1, 2010. His physical examination was found to be essentially unchanged. X-rays were taken of the left foot. He found minimal evidence of healing. There was noted to be less than a millimeter or two of bone fragment. Dr. Davis' assessment was that the Petitioner had a stable base of the left distal phalanx fracture of the great toe as well as dorsal foot neuropraxic injuries in both feet. Dr. Davis' report indicates that he felt it was safe for the Petitioner to return to work. He indicated that there may be some permanent deficit ultimately due to the nature of the injury and the neurologic complaints. With regard to the bone fracture, the doctor felt that it was stable enough that the Petitioner would not require surgical intervention. He was told to come back in two to three months' time for assessment. The Petitioner's full duty release to return to work was confirmed. (Pet.Ex.3)

Dr. Davis next examined the Petitioner on April 1, 2010. At that time the Petitioner complained of ongoing pain. He noted pain in the great toe region with some dorsal pain over the feet as well. Physical examination revealed no obvious atrophy, asymmetry of deformity. Dr. Davis noted some decreased sensation in a non-focal distribution of the dorsum of the foot. He also noted some tenderness over the IP joint of the left great toe. There was no tenderness or pain with the mid-foot squeeze test. There was good motion of the ankle. X-rays taken on this date showed distal phalanx fracture of the left great toe to be in good position although there was still a persistent fracture line. Dr. Davis' assessment was that the petitioner had a stable left great toe distal phalanx fracture which still showed some non-union along with a dorsal foot neuropraxic injury. The doctor discussed with the Petitioner the fact that the nature of the pain had been predominantly neuropraxic. The doctor suggested the Petitioner try a bone stimulator to promote osseous healing. The doctor continued to allow the Petitioner to work for a full day but requested that he take a 15 minute rest every two hours. (Pet.Ex.3)

The Petitioner last saw Dr. Davis on May 5, 2010. The doctor noted that he returned after undergoing bone stimulation for the distal phalanx fracture of the left great toe. The Petitioner reported that the pain had not significantly changed. Dr. Davis' physical examination was essentially unchanged. X-rays taken on this date showed that the fracture was healing. The clinical and radiographic impression was that of a healing left great toe distal phalanx fracture. Dr. Davis' final assessment was that the Petitioner had a healing left distal phalanx fracture of the great toe and some persistent neuropraxic discomfort. He noted that from a structural standpoint, the Petitioner's toe was as good as it was going to be. The doctor placed him at maximum medical improvement. He was given a full release. (Pet.Ex.3)

At Arbitration, the Petitioner testified that he returned to work for Midas for one day and was then laid off as he was told his services were no longer needed. The Petitioner then secured employment with Vic Koenig Chevrolet as an automobile mechanic. The Petitioner has worked for the Chevrolet dealership since July 2010 performing automobile and diesel repair services. The Petitioner was still employed at Vic Koenig Chevrolet as of the date of Arbitration performing automobile repair.

At Arbitration, the Petitioner testified that he had not sought treatment with any other orthopedic surgeons since Dr. Davis released him from care.

The Petitioner's attorney directed him to Dr. Louis Aquino, a podiatrist, for consultation. This visit took place on June 3, 2010. According to the report, the Petitioner complained of having quite a bit of pain in the interphalangeal joint of the left great toe, which had been previously treated by Dr. Davis. It was also noted that the Petitioner continued to complain of numbness as well as a pins and needles sensation in the dorsum of both feet. According to Dr. Aquino's report, the Petitioner reported that he could not be on his feet for any great length of time due to the pain he was experiencing in the interphalangeal joint of the left great toe. The nerve pain was noted to be minimal compared to the joint pain. During examination, the Petitioner was found to be neurologically and vascularly intact. The musculoskeletal examination revealed tenderness associated with the fracture located at the left distal phalanx of the great toe. Maximum tenderness was on the lateral aspect of the interphalangeal joint. Dr. Aquino reviewed x-rays dated 5/5/10 and noted a chip fracture of the lateral aspect at the base of the distal phalanx that involved the interphalangeal joint but did not show consolidation. The diagnosis was closed fracture of the phalangees of the foot. Dr. Aquino believed that the Petitioner would benefit from a surgical excision of the fracture fragment and repair of his extensor halluces longus tendon. (Pet.Ex.4)

The Petitioner returned to Dr. Aquino on January 13, 2011. The doctor noted that he had not seen the Petitioner since June of 2010. The Petitioner reported minimal improvement since the last visit. He complained of difficulty in being on his feet for any length of time and noted popping, clicking and grinding in the interphalangeal joint. X-rays taken on this date showed greater consolidation of the fracture site, although Dr. Aquino did not believe that complete healing had taken place. The doctor suggested attempting a cortisone injection into the interphalangeal joint for pain relief. He was of the opinion that the Petitioner had reached maximum medical improvement relating to the neuropraxia. (Pet.Ex.4)

Dr. Brian C. Schaffer examined the Petitioner at the Respondent's request on August 6, 2010. At the time of the examination, the Petitioner's complaints were located in the left big toe. Dr. Schaffer testified that the Petitioner did not make any complaints concerning his Lisfranc Joint. (Res.Ex.1 at 9)

Dr. Schaffer performed an examination of the Petitioner. With regard to the right foot, he noted some subjective decreased sensation to light touch over the dorsum but it was very close to normal. When examining the left foot, the doctor noted tenderness at the left great toe interphalangeal joint. There was full range of motion, however. There was no bruising or swelling and no abnormal skin changes. There was some subjective decreased sensation to light

touch on the left foot. The doctor found the Petitioner's gait to be normal. (Res.Ex.1 at 9) Dr. Schaffer found a lack of ecchymosis, which indicated that nothing acute was going on at the time. (Res.Ex.1 at 10) Dr. Schaffer had the Petitioner undergo x-rays in his office. Upon reviewing those films, the doctor found a fracture line near the base of the distal phalanx of the left great toe which appeared to be healed. He did not find any other pathology to any other area of the foot. (Res.Ex.1 at 11) Dr. Schaffer reached a diagnosis of the Petitioner's condition. He felt that he had some continued decreased sensation perhaps having an impaction injury to the sensory nerve on the dorsum of the feet. He felt that this would improve with time. He also felt that the Petitioner had a fracture that had healed. Dr. Schaffer noted that the area of the fracture could be painful for up to a year but it should not be a permanent problem. The doctor thought the Petitioner had reached maximum medical improvement and his fracture had healed. (Res.Ex.1 at 11)

Dr. Schaffer noted that nerve recovery can take a while, and that if nerves have not been severed they do tend to heal but it can take a year or more to get all of the sensation back. (Res.Ex.1 at 12) Dr. Schaffer felt the Petitioner had reached maximum medical improvement as of the examination date of August 6, 2010. He also felt the Petitioner was able to work without restriction. (Res.Ex.1 at 13) Dr. Schaffer testified that he also had occasion to review reports from Dr. Louis Aquino, the podiatrist. His review of those reports did not change any of his opinions. He also felt the Petitioner did not require any surgical treatment relating to the foot injuries of November 24, 2009. (Res.Ex.1 at 13-14)

Dr. Schaffer also testified that he reviewed an MRI that had been performed at Union County Hospital on June 2, 2011. Upon reviewing that MRI, he found no evidence of fracture or non-union. He felt that the great toe fracture had completely healed. (Res.Ex.1 at 15)

The Petitioner underwent an MRI at Union County Hospital in Anna, Illinois on June 2, 2011. The radiologist noted that the alignment of the left mid to fore foot showed no dislocation. There was no dorsal step off. The Petitioner also had no interspace widening and had intact Lisfranc ligament fibers. The bone marrow intensity showed no acute fracture, stress fracture or focal bone marrow edema. The final impression was no underlying accurate fracture, stress fracture or focal bone marrow edema. Intact Lisfranc ligament fibers were noted. (Pet.Ex.5)

The Petitioner did not again consult a physician for treatment until he went to Dr. Jeffery Appleman, a podiatrist, on December 22, 2011. The Petitioner testified that he had been referred there by Dr. Louis Aquino.

According to the office note, the Petitioner complained of chronic pain worsening with long hours of standing on concrete sometimes causing swelling. (Pet.Ex.6)

The examination by the doctor showed that the pulses were palpable. There was no evidence of reflex sympathetic dystrophy or regional complex pain syndrome. Neurologically the Petitioner was grossly intact. From an orthopedic standpoint, Dr. Appleman noted a Pes Cavus foot type with hypermobility to the first ray. Manual muscle testing was within normal limits. The doctor found re-producible pain on palpation to the area of the Lanfranc's joint in the medial column as well as to the second metatarsal area. X-rays were taken which demonstrated

atypical radiolucency associated with the Lisfranc joint, including the intermediate cuneiform which was non-acute. The doctor's assessment was Pes Cavus, pain, early osteoarthritic changes associated with the metatarsocuneiform region. Dr. Appleman felt the petitioner needed to stabilize his longitudinal arch and recommended the fabrication of custom function orthotics. (Pet.Ex.6)

At the 6/1/12 visit to Dr. Appleman, it was noted that the Petitioner complained of discomfort associated with his left foot near the first metatarsophalangeal joint. Examination revealed mild tenderness to deep palpation at the dorsal lateral aspect of the metatarsophalangeal joint with no sesamoid involvement. The doctor felt the Petitioner was suffering from simple capsulitis associated with the left first metatarsophalangeal joint and gave him some Celebrex. (Pet.Ex.6)

When the Petitioner returned to Dr. Appleman on November 5, 2012, he complained of persistent generalized foot pain which the doctor felt was consistent with plantar fasciitis. The doctor gave the Petitioner some Feldine for the plantar fasciitis type symptoms. He noted no evidence of acute fracture, subluxation or dislocation. (Pet.Ex.6)

At deposition, Dr. Appleman testified that the Petitioner had a Pes Cavus foot type, which is a very high arched foot. At the time of the first evaluation, he noted increased pain from the Lisfranc joint which was noted to be basically in the mid-foot in the second metatarsal area. (Pet.Ex.1 at 7) When asked to describe the Lisfranc area, the doctor noted that the Lisfranc joint is located where the metatarsals meet essentially in the mid-foot. The majority of the Petitioner's problems were toward the big toe side or the medial side. (Pet.Ex.1 at 8) Due to the type of foot the Petitioner had, Dr. Appleman recommended the custom orthotics. When asked whether the need for the orthotics was related to the 2009 work accident, Dr. Appleman noted that the work accident was two years earlier and the orthotics were meant to treat the condition he presented with and the pain that the Petitioner complained of at the initial assessment. (Pet.Ex.1 at 10) When asked whether the ongoing condition and the continuing need for orthotics was related to the work accident, Dr. Appleman testified that he was not really sure with regard to this condition and noted that there was some room for debate. He then went on to state that with regard to what the Petitioner was there for, he felt that it was probably an exacerbation of his initial complaint. (Pet.Ex.1 at 12) Dr. Appleman testified that when he first saw the Petitioner, the Petitioner complained of chronic left foot pain in the mid-foot area. He noted that it was not specifically located in the left great toe. In clarification, the doctor indicated that the Petitioner's pain was deep in his foot. (Pet.Ex.1 at 18) The doctor agreed that his records did not record the Petitioner complaining of any specific pain or symptoms in the left great toe. (Pet.Ex.1 at 18-19) The doctor also found that the Petitioner walked with a normal gait and his range of motion in the toes and the foot were all within normal limits. The Petitioner displayed no sensory alteration or loss. There were no signs of atrophy or muscle wasting. The doctor agreed that the Petitioner has a high arch which would be a congenital condition. (Pet.Ex.1 at 19-20) The doctor did not note any complaints on the right foot. The symptoms were all in the left. (Pet.Ex.1 at 20) Dr. Appleman testified that the focus of his treatment was on the arch of the foot rather than the toes. (Pet.Ex.1 at 20) Dr. Appleman agreed that the distal phalanx fracture from November 24, 2009 has fully healed. (Pet.Ex.1 at 20) He agreed that it did not require any additional treatment. He also agreed that it would be hard to determine whether

to attribute inflammation in 2011 back to the 2009 injury. He agreed that it could easily be due to other factors. (Pet.Ex.1 at 22) He agreed also that at the last visit in November 2012 the primary focus of the treatment appeared to be symptoms consistent with plantar fasciitis which was located more in the heal area. That complaint had not been present before November 5, 2012. He could not directly relate the presence of plantar fasciitis on November 5, 2012 to an accident that took place on November 24, 2009. (Pet.Ex.1 at 22-23)

At deposition, Dr. Brian Schaffer testified that after reviewing all of the records and diagnostic testing results, it was his opinion that the Petitioner did not need custom orthotics as a result of the accident of November 24, 2009. The doctor noted there were no abnormalities to the Lisfranc joint four weeks after the injury. He also noted that the June 2, 2011 MRI clearly showed intact Lisfranc fibers. He also found that there was no evidence of a bone bruise. The doctor stated that there was very strong evidence, at least as of June 2, 2011, that the Petitioner did not have an injury to the Lisfranc joint in the mid-foot. (Res.Ex.1 at 16-17) The Petitioner testified at Arbitration that he still had symptoms in the big toe to the mid-foot on both feet. He also complained of ongoing numbness and tingling to the top of the toes and in miscellaneous patches on top of his left foot. The left foot is more symptomatic than the right foot. The Petitioner testified that he wears the orthotics in his work boots but they do not fit in other shoes. He testified that he cannot wear sandals nor any type of non-lace up type of shoe. The Petitioner testified that he did not have problems lifting heavy items as long as he situated his feet in a certain way. He claimed that he walked on the outside of his feet due to the symptoms and has problems standing in one spot for long periods of time. He noted some difficulty with climbing stairs and he has given up riding his motorcycle. With regard to work, the Petitioner performs it at the same pace. He testified that he had no problems with his work as long as he takes some breaks. The Petitioner confirmed that he had been working since July of 2010 for the same employer. He is able to complete his work duties as required by his job.

CONCLUSIONS OF LAW

In regard to disputed issue (F), the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the Petitioner's condition of ill-being, as diagnosed and treated by Dr. Jeffrey Appleman, is not causally related to the accident of November 24, 2009.

In support of this conclusion the Arbitrator notes the following:

The Petitioner testified that when the lift came down on his feet on November 24, 2009, it struck the top of his feet and the big toe areas. On the top of the feet, the area injured went halfway up the top side of the feet. The initial treatment records from WorkCare of Herrin and Dr. J.T. Davis show the Petitioner's complaints were located in the left great toe and the upper parts of his feet. The Petitioner was diagnosed as suffering from a fracture to the distal phalanx of the left great toe along with some neuropraxic injury to the dorsal part of the feet. There was no damage to the bones of the right foot, as shown on multiple x-rays. X-rays reveal that the Petitioner sustained the fracture to the left great toe. The focus of the care provided by Dr. Davis between November 27, 2009 and May 5, 2010 was to the left great toe and the areas on the top of the feet. There was no indication of any pain in the mid-foot or the lower part of the feet. The

ankles were found to be intact. There was no injury to the metatarsal bones nor was there any injury to the heel areas. The orthopedic surgeons focus remained on the fracture to the great toe and the superficial nerve contusions. Dr. Davis felt the Petitioner was at maximum medical improvement as of 5/5/10 and gave him a full release at that time.

When the Petitioner consulted with Dr. Aquino, at his attorney's direction, the Arbitrator notes that this physician also examined the Petitioner for left great toe pain along with a complaint of numbness along with a pins and needles sensation in the dorsum, or the top, of both feet. Dr. Aquino did not document any symptoms or abnormalities deep into the foot or in the lower part of the foot involving the metatarsal joints. Dr. Aquino eventually expressed the opinion that the Petitioner reached maximum medical improvement with regard to the neuropraxic or nerve injuries to the top of his feet. He suspected that the interphalangeal joint fracture in the left great toe had not completely healed. Eventually, this joint was shown to be completely healed, as documented in the MRI taken at Union County Hospital in Anna, Illinois on June 2, 2011. That test also showed the remainder of the bones of the feet to be in good condition. There was no evidence of injury to the Lisfranc joint nor was there any sign of focal bone marrow edema.

The Arbitrator notes that when the Petitioner began treating with Dr. Appleman, which commenced over three years post-accident, Dr. Appleman's focus appears to be in the arch of the foot and in the Lisfranc joint area. Dr. Appleman has been focusing on the Petitioner's foot type and areas that are different from the areas injured on November 24, 2009. The Arbitrator's review of Dr. Appleman's reports and testimony shows that Dr. Appleman was treating a different area of the foot which was not symptomatic during the treatment that took place immediately following the accident. The Arbitrator therefore does not find that this current treatment as commencing on December 22, 2011 is causally related to the accident of November 24, 2009. Dr. Appleman agreed that the left great toe fracture was healed and that the Petitioner was not making complaints in that area. Dr. Appleman also did not document the presence of any right foot complaints as related by the Petitioner at Arbitration.

The Arbitrator therefore concludes that the treatment provided by Dr. Appleman is to a different area of the foot and that the long gap in time between the accident and the documented onset of the treatment to the mid-foot on the lower side do not support a finding of causal connection with the accident of November 24, 2009.

In regard to disputed issue (J), the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the medical services provided to the Petitioner from 11/25/09 through 5/5/10 were reasonable and necessary and the Respondent is liable for payment of those medical expenses.

The Respondent is also found to be liable for the medical service provided on 6/22/11 at Union County Hospital of Anna, Illinois and the Arbitrator notes that the Respondent has paid that expense pursuant to Section 8.2 of the Act.

In support of this conclusion the Arbitrator notes the following:

The Petitioner was found to be at maximum medical improvement by Dr. J.T. Davis on 5/5/10. The Arbitrator also notes that the medical evidence does not support causal connection and compensability between the accident of 11/24/09 and the treatment provided by Dr. Jeffrey Appleman subsequent to 12/22/11. As the Arbitrator as found that the Petitioner's current condition of ill-being as diagnosed and treated by Dr. Appleman is not causally related to the accident of 11/24/09, payment of those medical bills is hereby denied.

In regard to disputed issue (L), the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that the Petitioner has sustained permanent partial disability to the extent of 20% loss of use of the left foot and 10% loss of use of the right foot.

In support of this conclusion the Arbitrator notes the following:

The Petitioner sustained a crush injury to the top half of his feet on November 24, 2009. The Petitioner sustained a neuropraxic injury to the nerves in the top of his feet bilaterally, with the left foot sustaining greater injury. The Petitioner also sustained a fracture to the distal phalanx of the left great toe. This fracture has been documented to have healed. The Petitioner returned to work as a mechanic and has worked in that field since July 2010. He has worked for the same employer throughout that period and testified that he is able to carry out his work duties and performs his work at the same pace as he always has. The Petitioner remains employed as a mechanic in an automobile dealership.

The Arbitrator notes that the injury of 11/24/09 was confined to the left great toe and the dorsal area of both feet. As the Petitioner's current treatment is focused in the lower foot at the mid-foot area, involving the Lisfranc joint and the metatarsals, the Arbitrator attributes no permanent partial disability to these conditions as they arose long after the Petitioner had been declared at maximum medical improvement by the treating orthopedic surgeon, Dr. J.T. Davis.

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 Choose reason	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☒ Modify Choose direction	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

CAROLYN SCHOONOVER,

Petitioner,

vs.

NO: 05 WC 51841
05 WC 51842
08 WC 15248

PORTA COMMUNITY UNIT SCHOOL DISTRICT. #202,

Respondent.

15IWCC0634

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, prospective medical, penalties and attorney fees, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

The Commission initially notes that three separate cases (05 WC 51841, 05 WC 51842 and 08 WC 15248) were tried in consolidated fashion before the Arbitrator on October 15, 2014. The Arbitrator issued a single decision document with regard to all three cases. The Commission, in also issuing a single decision for all three cases, wishes to make it clear that the entire Arbitrator's decision is affirmed and adopted for all three cases, other than the modifications noted below.

15IWCC0634

The Commission finds that the causal connection of the Petitioner's cervical spine condition ended as of July 7, 2005. At that time, Dr. MacGregor, who had been treating Petitioner for her lumbar and cervical conditions related to her January 31, 2003 accident (the subject of case number 05 WC 51842), indicated the Petitioner had reached maximum medical improvement and was able to return to her regular duty job.

The Petitioner then continued to work, other than for a period of time in 2006 unrelated to the cervical spine, until sustaining an accident on November 7, 2007 (the subject of case number 08 WC 15248). She visited Menard Medical Center (her primary care provider) (Px2), Dr. MacGregor (Px4), Dr. Silvieri (Px8), Dr. Soriano (Section 12 examiner, Rx9) and Dr. Fletcher (Section 12 examiner, Rx10) after that date, and prior to October 14, 2011.

Dr. Thompson on October 14, 2011 notes Petitioner reported some neck pain, and on October 28, 2011 a cervical MRI was performed. In a thorough review of the medical evidence in this case, the Commission sees no mention of ongoing cervical complaints to any of the noted physicians or medical facilities between July 7, 2005 and October 14, 2011, and she received no cervical treatment. Thus, the first post-November 7, 2007 indication of complaints of the cervical spine did not occur until almost four years after Petitioner's last claimed accident. Based on the July 7, 2005 full duty release of Petitioner at maximum medical improvement and a lack of ongoing cervical complaints until October 14, 2011, the Commission finds that the causal connection of the Petitioner cervical condition to the January 31, 2003 accident ended as of July 7, 2005. Because there is no evidence of complaints or treatment to the cervical spine after the November 7, 2007 accident until October 14, 2011, the Commission also finds that any ongoing cervical condition is not related to the November 7, 2007 accident.

We also affirm the Arbitrator's denial of penalties and attorney fees. The Respondent was entitled to defend itself based on the Petitioner's ongoing smoking, the lack of veracity about her ongoing smoking with her treating doctors, and the opinions of Dr. Soriano and Dr. Fletcher. We see nothing unreasonable or vexatious in the Respondent's defense of these claims, and any delay in benefits was not unreasonable given the totality of the evidence.

Based on the Petitioner's failure to stop smoking, or to make any significant and consistent attempts to quit, we find that the Petitioner has reached maximum medical improvement as of February 17, 2010, the date Dr. MacGregor initially indicated that she would not proceed with surgery unless Petitioner completely stopped smoking, and Petitioner, after initially indicated she had cut back on smoking, actually had not reduced her smoking at all. Dr. MacGregor's records make it quite clear that the Petitioner was advised multiple times that lumbar surgery could not be performed unless and until she completely quit smoking. The records also indicate both Petitioner's failure to do so, as well as Petitioner's belief that "she feels as though her symptoms warrant surgery regardless of her smoking" (see Px4, 3/11/10). Dr. MacGregor testified that she felt Petitioner did not make a genuine effort to stop smoking, and Petitioner apparently indicated this was due to family stress. (Px17, pp. 45-49). The records and testimony of Dr. MacGregor reflect a claimant who complains of significant and severe symptoms, but who is unwilling to do what she needs to do in order to obtain relief. In our view, this indicates that her symptoms must not be as significant as she claims, or she would have ended her smoking long ago. Petitioner herself indicated to Menard Medical Center on August

15IWCC0634

27, 2012 that she was afraid of surgery and didn't know if she would be willing to undergo it. (Px2). On December 13, 2010, Dr. MacGregor released Petitioner to the care of Petitioner's general practitioner, Dr. Thompson, due to her failure to quit smoking. While the Commission understands that quitting smoking is not an easy task, the number of times the Petitioner has been advised to do so in this case, going back to 2004 by Dr. MacGregor, should have been enough for her to quit. We do not believe that the Petitioner provided the necessary effort to do so and to undergo surgery, and as such her own actions, both in failing to stop smoking and in being less than truthful with Dr. MacGregor with regard to her attempts to do so, have dictated this result.

Given the minimal amount of medical visits and treatment she has had since February 17, 2010, we affirm the Arbitrator's award of medical expenses through October 15, 2014.

These claims are remanded to the Arbitrator for a determination of permanent disability, if any.

Neither party presented applicable fee schedule figures with regard to the medical bills at issue. The Petitioner has presented medical expenses totaling $199,094.16 (Px15). Respondent has presented evidence of medical payments totaling $70,707.53 (Rx7). Taking this along with the TTD awarded ($52,644.15) and previously paid by and credited to Respondent ($27,541.26), the bond in this case is the maximum $75,000.00.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator is modified as indicated above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $179.83 per week for a period of 129-1/7 weeks, and the sum of $253.00 per week for a period of 116-2/7 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 all reasonable and necessary medical services incurred between January 10, 2003 and October 15, 2014, related to her lumbar spine, throat and smoking cessation, pursuant to §§8(a) and 8.2 of the Act. The Respondent also shall pay to Petitioner all reasonable and necessary medical services incurred between January 10, 2003 and July 7, 2005, related to her cervical spine pursuant to §§8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

15IWCC0634

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent is entitled to a credit for its payment of any and all related medical expenses pursuant to §8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any providers of the benefits for which Respondent is receiving credit under this order.

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

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

DATED: AUG 18 2015
TJT: pvc
O 06/23/15
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

SCHOONOVER, CAROLYN
Employee/Petitioner

Case# **05WC051841**

05WC051842
08WC015248

PORTA COMMUNITY UNIT SCHOOL DISTRICT #202
Employer/Respondent

15IWCC0634

On 11/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2778 DRAKE NARUP & MEADE PC
STEVEN C WARD
107 E ALLEN ST
SPRINGFIELD, IL 62704

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

15IWCC0634

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CAROLYN SCHOONOVER,
Employee/Petitioner

v.

PORTA COMMUNITY UNIT SCHOOL DISTRICT #202
Employer/Respondent

Case # **05** WC **51841**

Consolidated cases: **05 WC 51842 and 08 WC15248**

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 H. Pulia**, Arbitrator of the Commission, in the city of **Springfield**, on **10/15/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the dates of accident, **1/10/03, 1/31/03, and 11/7/07**, Respondent *was* operating under and subject to the provisions of the Act.

On these dates, an employee-employer relationship *did* exist between Petitioner and Respondent.

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

Timely notice of these accidents *was* given to Respondent.

Petitioner's current condition of ill-being *is not* causally related to the accident petitioner sustained on 1/10/03.

Petitioner's current condition of ill-being as it relates to her cervical spine *is* causally related to the accident on 1/31/03.

Petitioner's current condition of ill-being as it relates to her lumbar spine *is* causally related to the accident on 1/31/03 only through 11/6/07.

Petitioner's current condition of ill-being as it relates to her lumbar spine *is* causally related to the accident on 11/7/07.

In the year preceding the injuries on 1/10/03 and 1/31/03, Petitioner earned $**14,027.00**; the average weekly wage was $**$269.75**.

In the year preceding the injury on 11/7/07, Petitioner earned $**11,837.78**; the average weekly wage was $**$312.20.**

On the dates of accident 1/10/03 and 1/31/03, Petitioner was **46** years of age, ***married*** with **no** dependent children.

On the date of accident 11/7/07, Petitioner was **51** years of age, ***married*** with **no** dependent children.

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

Respondent shall be given a credit of $**27,541.26** for TTD, $**00.00** for TPD, $**00.00** for maintenance, and $**00.00** for other benefits, for a total credit of $**27,541.26**.

Respondent is entitled to a credit of $**00.00** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $179.83/week for 1-1/7 weeks, commencing 1/13/03 through 1/20/03, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $179.83/week for 128 weeks, commencing 2/3/03 through 7/18/05, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $253.00/week for 116-2/7 weeks, commencing 11/10/07 through 2/1/10, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services petitioner received from 1/10/03 through 10/15/14 for treatment related to her lumbar spine, cervical spine, throat and smoking cessation, 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.

Petitioner's claim for penalties and fees pursuant to Sections 16, 19(k) and 19(l) of the Act are denied.

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

10/30/14
Date

ICArbDec19(b)

NOV 5 - 2014

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 46 year old bus monitor, on 1/10/03 (05 WC 51841) and 1/31/03 (05 WC 51842), and 51 year old bus monitor on 11/7/07 (08 WC 15248), sustained accidental injuries that arose out of and in the course of her employment by respondent. At trial petitioner amended her date of accident with respect to case 05 WC 51841 from 11/18/02 to 1/10/03. This motion was not objected to by respondent.

Petitioner testified that on 1/10/03 while riding respondent's bus and serving as a bus monitor the bus hit a bump and she went up in the air and came back down hard. Petitioner filed an accident report. She alleged injuries to her lower back.

On 1/13/03 petitioner presented to Dr. Redding at Menard Medical Center. When she called to get an appointment she complained of real bad low back pain. On examination she complained of severe left sided low back pain radiating to her legs on occasion. She denied any numbness or tingling. Tenderness was noted over the L5-S1 joint. She was assessed with low back pain and prescribed Celebrex and Tylenol 3. She was authorized off work until 1/21/03. Petitioner was returned to work on 1/21/03. She testified that she was doing good at that time.

On 1/31/03 the bus on which petitioner was working as a bus monitor ran into the back of a stopped truck. Petitioner testified that at the time of impact she was slumped forward and struck her left shoulder. She testified that she was flung forward and backwards after impact, and twisted her body at her waist. She complained of pain on her left side including her left shoulder, left ankle, back and neck. Petitioner was taken by ambulance to the emergency room at St. John's Hospital. Petitioner reported that she was unrestrained. She stated that she twisted. She complained of a burning sensation in her left shoulder, left ankle pain, and a back injury. X-rays of the left shoulder and lumbar spine were negative for fractures. She was assessed with multiple contusions.

That same day petitioner called Dr. Redding at 3:15 pm. She reported that she was in a bus accident that morning and was seen at the emergency room at St. John's. She requested an appointment to see Dr. Redding. She complained of back pain and stated that she was given Vicodin, but lost it. Dr. Redding's office refilled the Vicodin prescription.

That same day petitioner completed an Illinois Form 45. She identified the nature of her injury as multiple contusions to the left side of her body-neck.

On 2/3/03 petitioner presented to Dr. Redding. She complained that she was sore all over. She complained of burning in her neck and down her left shoulder, and in her left chest under her breast. She

also complained of low back pain. Petitioner was assessed with a cervical strain. She was prescribed medications and was taken off work from 2/3/03 to 2/10/03.

That same day petitioner completed an Injured Worker's Report of Injury for the injury on 1/31/03. She identified the nature of her injury as neck, left shoulder, arm, back and left side of body.

On 2/7/03 petitioner called Dr. Redding's office and complained of shoulder and neck pain. Petitioner was prescribed a course of physical therapy. Her diagnosis remained cervical strain due to motor vehicle accident. On 2/10/03 petitioner was authorized off work from 2/10/03 through 2/14/03. On 2/13/03 petitioner reported that she was somewhat better, and her neck pain was better. She complained of more low back pain. Petitioner was examined and assessed with a cervical strain and low back pain. Petitioner was authorized off work from 2/17/03 through 2/21/03.

On 2/21/03 petitioner called Dr. Redding's office and requested another off work slip because she still had some neck pain. Dr. Redding authorized petitioner off work from 2/24/03 through 2/28/03. On 2/28/03 petitioner again called Dr. Redding's office and requested another off work note for two more weeks. Dr. Redding authorized petitioner off work until further notice.

On 3/14/03 petitioner followed up with Dr. Redding still complaining of burning pain between her shoulder blades and down her right arm, and left arm. She denied any numbness or tingling. Petitioner stated that she wanted to return to work on a limited basis. Petitioner was assessed with thoracic back pain following motor vehicle accident, with slow improvement. Petitioner was released to work from 7:45 am to 12:30 pm daily, with no bus riding. That same day, Dr. Redding also drafted a script taking petitioner off work from 3/17/03 through 3/28/03. She was continued in physical therapy.

On 3/25/03 petitioner underwent a cervical spine x-ray. No fractures or subluxation were noted. On 3/28/03 petitioner complained of increased pain in her neck and across her shoulder blades. Her assessment was cervical strain/chronic after motor vehicle accident. She was continued off work and physical therapy was discontinued.

On 4/14/03 petitioner returned to Dr. Redding complaining of tingling in the fingers of her left hand and pain between her shoulder blades. She also complained of pain extending down her left leg and trouble walking. She was assessed with a cervical strain (whiplash injury). An MRI of the cervical and thoracic spine was ordered.

On 4/15/03 petitioner underwent an MRI of the thoracic spine and cervical spine. The findings were degenerative change in the lower cervical spine with a disc bulge central and to the right at C5-C6,

and some loss of normal cervical lordosis. The results of the thoracic spine MRI were Syrinx cavity, otherwise normal.

On 4/25/03 petitioner initially presented to Dr. Smucker for evaluation of her neck and low back complaints. Petitioner denied any prior history of neck or low back problems. She provided a consistent history of the accident on 1/31/03 and her treatment to date. Following an examination Dr. Smucker's impression was cervicothoracic strain/sprain with associated left upper extremity parathesia but no clear abnormality on neurologic exam; cervical MRI that revealed rightward C5 – C6 disc bulge of unclear significance; lumbar strain/sprain; and left upper and lower extremity parathesias, and possible radiculopathy versus parathesias associated with soft tissue/myofascial pain syndrome. Dr. Smucker ordered an EMG of the left upper and lower extremities, resumption of physical therapy, and continued petitioner off work. An EMG/NCS of the left upper extremity was normal. Dr. Smucker also ordered a course of physical therapy.

On 5/23/03 petitioner returned to Dr. Smucker. Her complaints were essentially the same. Dr. Smucker assessed cervicothoracic sprain/strain with associated left upper extremity parathesias, and a normal EMG/NCV of the left upper extremity. He also noted that the cervical MRI revealed rightward C5 – C6 disc bulge of unclear significance, lumbar strain/sprain, left lower extremity parathesias, and possible radiculopathy versus parathesias associated with soft tissue/myofascial pain syndrome. He recommended an MRI, and EMG of the left lower extremity. He noted that physical therapy had been put on hold, and gave petitioner a note to be off work until further notice. On 6/19/03 petitioner returned to Dr. Smucker and stated that she was feeling somewhat worse. His impression and recommendations remained the same.

On 7/17/03 petitioner initially presented to Dr. Margaret McGregor with a chief complaint of neck, left arm, back, and leg pain since 1/31/03. Petitioner reported that prior to January 2003 she never had any significant problems, other than normal backaches. She stated that on 1/10/03 she bounced up off the seat, slammed down back on the seat, and developed low back pain. She also gave a history of an accident on 1/31/03 where the bus struck a very large truck that was stopped. She stated that she struck her left side. Following an examination Dr. McGregor diagnosed C5 – C6 herniated nucleus pulposus. She recommended an image of the lumbar spine, thoracic spine with contrast, epidural steroid injections, Medrol Dosepak, and FCE to determine her ability to return to work.

On 8/1/03 petitioner returned to Dr. Smucker. Dr. Smucker recommended a lumbar MRI scan, and Medrol Dosepak. He continued petitioner off work.

On 8/12/03 petitioner underwent an MRI of the lumbar spine that showed minimal to mild focal foraminal protrusion on the right of the L5 – S1 intervertebral disc with mild narrowing of the lateral recess.

On 9/4/03 petitioner followed up with Dr. Smucker. Dr. Smucker noted that in the absence of a positive EMG test and only a small disc bulge seen on the MRI scan that there was only about a 6% chance of improvement with a cervical epidural injection series. He recommended a left lower extremity EMG/NCS to look for evidence of radiculopathy. He continued petitioner off work until 9/24/03.

On 9/24/03 petitioner underwent a repeat EMG/NCS. The conclusions were mild subacute left S1 radiculopathy. On 9/29/03 petitioner underwent a left C6-C7 trans-laminar epidural steroid injection. On 10/13/03 petitioner underwent a left C6 – T1 trans-laminar epidural steroid injection. On 10/22/03 she returned to Dr. Smucker and stated that she was feeling significantly better. She continued to complain of pain in her low back with radiation to the right thigh, and into the heel on the left side. Dr. Smucker recommended lumbar epidural injections, reinstatement of physical therapy, 10 pound max lifting at work, and sit/stand option through 11/22/03.

On 10/27/03 petitioner underwent a left L5 and S1 transforaminal epidural steroid injection. On 11/6/03 she reported to Dr. Smucker that the injection went well. She stated that she was able to get around and do a little more. A second epidural steroid injection into the lumbar spine was recommended. Dr. Smucker continued petitioner's restrictions. Petitioner stated that she was unable to work until she can return to work full duty. Physical therapy was continued. On 11/17/03 petitioner underwent a second left L5 and S1 transforaminal epidural steroid injection.

On 12/3/03 petitioner returned to Dr. Smucker and stated that she was extremely pleased with the results of the injection. She stated that her low back and her left leg pain were much better, to the point where it was essentially gone. Petitioner complained of pain in her upper thoracic region. Dr. Smucker was of the opinion that petitioner was nearing maximum medical improvement, unless it was determined that a surgical procedure would help her. He referred petitioner back to Dr. McGregor. He noted that if Dr. McGregor did not recommend any surgical intervention that an FCE would be appropriate. Dr. Smucker released petitioner to work on 12/3/03 with the same restrictions.

On 1/2/04 petitioner followed up with Dr. Smucker. She stated that she was doing worse. She complained of pain in her neck, upper shoulder girdle, and some radiation of parathesias into the left upper extremity. She also complained of ongoing low back and left posterior thigh discomfort. Dr.

Smucker's impression was cervicalgia with cervical degenerative disc disease, that was improved following a cervical epidural steroid injection, and lumbar left lower extremity radicular symptoms incompletely improved with two lumbar epidural injections. He continued petitioner's work restrictions of 10 pound maximum lifting with sit/stand option.

On 1/29/04 petitioner presented to Dr. MacGregor reporting that the two cervical and two lumbar epidural steroid injections helped her low back pain. She continued to complain of neck soreness and headaches. Dr. MacGregor was of the opinion that petitioner had a cervical disc herniation that was nonresponsive to conservative therapy. She recommended an anterior cervical decompression and fusion. It was noted that petitioner would quit smoking prior to the procedure.

On 2/17/04 petitioner underwent an anterior cervical decompression and fusion with arthrodesis, introduction of 8 mm lordotic interbody spacer, and plating from C5 - C6. This procedure was performed by Dr. MacGregor. Petitioner's postoperative diagnosis was C4-C5 herniated disc. Petitioner followed-up postoperatively with Dr. MacGregor. On 4/1/04 petitioner stated that 95% of her pain was related to her back pain. Dr. MacGregor continued petitioner in physical therapy and off work. She ordered a discogram.

On 4/16/04 petitioner underwent a discogram. The results were annular disruption on the right at L5 – S1, and a positive discogram at L5 – S1. Petitioner was instructed to return on 5/6/04 to discuss surgical options and interventions. On 5/6/04 petitioner reported that she was improved after her cervical fusion and was ready for her lumbar fusion. However, Dr. McGregor noted that petitioner was still noncompliant with smoking recommendations.

On 5/17/04 petitioner presented to Dr. Pineda for evaluation. Petitioner stated that she smokes a pack a day and has done so for many years. Her primary complaint was low back pain. She stated that it originated after, or was significantly aggravated by, an accident on or around 1/31/03. Dr. Pineda was of the opinion that petitioner had an option to continue to undergo observation, or undergo surgical intervention in the form of a fusion. Dr. Pineda released petitioner on an as needed basis.

On 6/30/04 petitioner underwent a lumbar vertebral fusion, arthrodesis of the lumbar spine by posterior interbody technique, spinal instrumentation posterior non-segmental, and neurological surgery laminectomy. This procedure was performed by Dr. MacGregor and Dr. Pineda. Petitioner's postoperative diagnosis was degenerative disc disease at L5-S1. Petitioner followed up postoperatively

with Dr. MacGregor. This treatment included a course of physical therapy. On 7/7/04 Dr. Pineda was fit with an orthosis.

From 10/1/04 through 11/15/04 petitioner underwent work hardening at Midwest Rehabilitation. On 11/15/04 petitioner was currently functioning just below the light physical demand level which includes material handling just below 20 pounds occasionally, 10 pounds frequently, and negligible weight constantly.

On 9/27/04 petitioner reported that she was feeling good. She was observed walking and sitting comfortably with her weight evenly distributed. Her motor strength was full throughout. Dr. MacGregor was of the opinion that petitioner should return to work by 11/1/04. Petitioner returned to Dr. MacGregor on 11/15/04 reporting pain in her neck and in between her shoulder blades more to the right side. She also complained of a spot on her right low back pain that had a numb painful feeling when walking. She stated that she was still smoking one pack of cigarettes per day. Dr. MacGregor released petitioner to return to work "just below light physical demand". She stated that petitioner would not be at MMI until February for her neck, and June for her lumbar spine.

On 1/6/05 Matthew Brue, superintendent with respondent, sent a letter to "to whom it may concern". He noted that attached was a work restriction form for petitioner regarding her work status. He noted that petitioner was released to return to work with modified duty. He stated that unfortunately respondent did not have any position currently available that would meet petitioner's needs, without jeopardizing a recurring injury because of the restrictions placed on her return to work. He stated that as noted in the work-release petitioner may not lift a significant amount of weight and the position that is available requires lifting in excess of that restricted weight. He noted that while the respondent would like petitioner to return to work, they could not risk petitioner being injured again.

On 2/14/05 petitioner returned to Dr. MacGregor and reported some residual complaints following her surgery. Petitioner stated that she was unable to return to work by respondent. Dr. MacGregor recommended a functional capacity evaluation at the end of June to determine permanent restrictions.

On 6/20/05 and 6/21/05 petitioner underwent a functional capacity evaluation. During this evaluation petitioner noted that she had been hoeing and gardening at home until she gets sore and then quits. She also stated that she does do grocery shopping, vacuuming, laundry, and dishes. Based on the results of the functional capacity evaluation it was recommended that petitioner continue her home exercise program, as previously instructed in physical therapy/work hardening, to include lumbar and

cervical stretching exercises, lower extremity strengthening exercises, and lumbar stabilization exercises. It was also recommended that petitioner continue to gradually increase her activity levels with home activities, and perform cardiovascular activities more faithfully. It was noted that petitioner had demonstrated very significant gains in her lifting capacities compared to those when in therapy. It was noted that petitioner was currently functioning within the lower realm of the lifting requirements for her job and appeared to be doing so safely. The therapist noted that if petitioner could work in the lower weight level of her job requirement then petitioner would be medically stable and could safely attempt to return toward her previous duties.

On 7/7/05 petitioner followed up with Dr. MacGregor. She stated that had a feeling of a lump in her throat, intermittent pain in the left ankle and sometimes both legs. She indicated that she is ready to go back to work. After reviewing the functional capacity test Dr. MacGregor released petitioner to full duty status at her regular job as of 7/11/05. She was of the opinion that petitioner had reached maximum medical improvement.

On 8/26/05 petitioner presented to Dr. Aldridge at Menards Medical Center. She reported that it felt like something was stuck in her throat. She stated that these problems have been present since her surgery. She also complained of hoarseness. Petitioner was referred to an ENT.

On 9/9/05 petitioner presented to Dr. Woodson. She was of the opinion that petitioner had severe laryngitis, probably reflux in origin, plus leukplakia of the larnyx. The plan was to maximize petitioner on acid suppression therapy included Nexium and Zantac.

On 12/5/05 petitioner returned to Dr. Woodson. She stated that she had been on Nexium and Zantac for three months. She stated that she still has a globalist sensation of hoarseness that has not gotten better. Dr. Woodson performed a flexible laryngoscopy. Dr. Woodson's impression was laryngopharyngeal reflux, and leukoplaxia. Her plan was to perform a micro direct laryngoscopy in the near future and remove the masses. She continued petitioner on Nexium and Zantac.

On 2/10/06 petitioner returned to Dr. Aldridge. She complained of bilateral hip pain, and problems with her arms/wrist strain. She also complained of headaches. Petitioner was assessed with arm weakness and SI joint pain. She was referred back to Dr. MacGregor.

On 3/23/06 Dr. Woodson performed a micro direct laryngoscopy with excision of true and false vocal cord lesions. On 3/31/06 Dr. Woodson noted that petitioner was doing well. She authorized petitioner off work for at least one month. She was instructed not to put any undue stress on her voice.

On 4/18/06 petitioner underwent a Section 12 examination performed by Dr. Fletcher. Following a record review and examination Dr. Fletcher disputed that petitioner's current condition of ill being is work related. He stated that her causal connection was negated by the significant gap between her accident on 1/30/03 and the onset of her low back pain that resulted in a fusion on 6/04. He also believed that both petitioner's neck and lower back surgery were unreasonable and unnecessary based on his examination and review of her records. He disputed any connection between her recent ENT surgery and her 1/30/03 work injury. Dr. Fletcher indicated that it would be helpful if he could review the emergency report from St. John's Hospital dated 1/30/03 and the police reports. He also stated that he needed Dr. Woodson's notes from petitioner's recent 3/27/06 throat surgery. Dr. Fletcher was of the opinion that petitioner incurred no permanent loss from her two work injuries, and that no permanent job restrictions were necessary. He opined that she was at MMI from her work injuries.

On 5/1/06 petitioner returned to Dr. Woodson. She stated that she had no improvement in her symptoms. She stated that she has smoked one pack of cigarettes a day for the past 35 years. Dr. Woodson performed a procedure that revealed left true vocal cord hyperkeratosis, left false cord papilloma, and gastroesophageal reflux disease with associated laryngopharyngeal reflux. Petitioner was referred to SIU Gastroenterology. Petitioner was authorized off work until the end of June.

On 5/4/06 Dr. Woodson drafted a letter to "to whom it may concern". She stated that she'd been treating petitioner since 9/9/05 and noted that her problems began after spinal surgery in February 2004. She was of the opinion that most likely petitioner had laryngeal damage due to intubation from that surgery. She was of the opinion that the injury had been exacerbated, and healing prevented due to extraesophageal acid reflux disease and the strain on her voice due to the need to speak loudly over a noisy environment at work. She noted that she had treated petitioner with aggressive acid suppression and she gradually improved. She stated that she still has persistent laryngeal swelling and irritation, and that she was referring her to a gastroenterologist for evaluation. Dr. Woodson was of the opinion that petitioner needed to limit her voice use. She was of the opinion that the level of speech required by her job caused further damage to this injured larnyx.

After receiving and reviewing additional records on 5/12/06 Dr. Fletcher drafted an addendum report. He stated that these records did not change his opinion and only strengthened his original opinions. He disputed any causal connection for both the neck and back based on the emergency room record at St. John's Hospital dated 1/31/03, a complaint of injury bouncing around the bus on 12/20/02, and low back complaints on 1/13/03 with no history of injury.

On 6/15/06 petitioner returned to Dr. MacGregor stating that she had been having some intermittent troubles. These included lifting objects, low back pain when sleeping, and leg pain when walking. She stated that all the symptoms were intermittent. A physical examination revealed that petitioner had full strength throughout. Petitioner stated that she can live the way she is. Dr. MacGregor discussed the different options for using pillows and her mattress. She released petitioner on an as needed basis.

On 7/5/06 Dr. Fletcher drafted a letter to respondent's attorney. In that letter he stated that he examined petitioner on 4/18/06 and disputed that her present condition was causally related to her two work injuries. After reviewing the records of Dr. Woodson and his associates, Dr. Fletcher denied any causal connection between petitioner's surgical fusion and her ENT problems that required surgery on 3/23/06. He noted that she was a smoker, has reflux, which along with smoking is another risk factor for the development of laryngeal problems, especially hoarseness. He was of the opinion that while a person can develop as a complication of her cervical fusion an injury to the laryngeal nerve, these individuals develop hoarseness soon after the surgery. He was of the opinion that in this case there were no documented complaints until 7/7/05, 15 months after her neck surgery when she reported to Dr. MacGregor that she had a lump in her throat.

On 7/21/06 petitioner presented to Dr. Syed with complaints of mild dysphasia. She stated that she has discomfort when she swallows solid foods. Petitioner stated that this problem occurred after her surgery. Following an examination Dr. Syed's impression was that petitioner was a female with an average risk for colon cancer. A colonoscopy was recommended and petitioner agreed. Dr. Syed noted no significant evidence of reflux esophagitis and noted that there had not been any improvement in petitioner symptoms since taking Nexium and Zantac. Dr. Syed recommended that petitioner stop Nexium and Zantac.

On 8/10/06 Dr. Woodson examined petitioner and released her to full duty work that day. She was instructed to follow-up in 6 months.

On 8/10/06 petitioner presented to Dr. Aziz. He was of the opinion that petitioner did not have a papilloma that was visible, but appeared to have some scarring on her vocal cord. He stated that it is likely that petitioner's hoarseness may not improve given that this is due to scarring.

On 4/16/07 petitioner returned to Menard Medical Center. She stated that she had been outside doing yard work and inhaled a lot of smoke. She also stated that she had been lifting small children at her job. She was examined and assessed with the chest wall pain and muscle strain.

On 11/13/07 petitioner requested a referral to Dr. Silveri for her low back.

On 11/28/07 petitioner completed an Injured Worker's Report of Injury. She stated that her injury occurred during the week of 11/5/07 through 11/9/07 in the morning. She reported that she injured her low back trying to keep a child from kicking other students inside the building. She stated that she had to set him down on the floor two times, and had to hold him so he would not kick her. She stated that he almost pulled her over on top of him. She noted that he head butted her in the stomach, and she had to pick him up to put him in his seat while he was kicking and hitting her. She noted that she stood in front of him so he wouldn't kick students while they were going by. She stated that she was kicked in the back and the stomach several times during the week.

On 11/28/07 petitioner presented to Dr. Meeks complaining of back pain. She gave a history of having interaction with a bad child at school. She stated the child was kicking, fighting, pulling, and pushing. She stated that she had the child in a bear hug and has had pain since then. She reported that the pain radiates down into her buttocks and down her right leg. She also complained of numbness in her great toe and second toe on the right. Petitioner was assessed with lumbar pain, and lumbar radiculopathy.

On 1/22/08 petitioner underwent an MRI of the lumbar spine. The impression was prior fusion at the lumbosacral junction. Also noted was moderate degenerative changes at the level of the L4 – L5 just above the fusion. On 1/25/08 petitioner returned to Menard Medical Center complaining of right shoulder pain since 2:30 AM that morning. She also complained of a lot of back pain.

On 1/28/08 petitioner underwent a Section 12 examination performed by Dr. David Fletcher at Safe Works Illinois, at the request of the respondent. Dr. Fletcher performed an examination and record review. Dr. Fletcher noted that petitioner wore a back brace during the functional capacity evaluation and examination. Dr. Fletcher found petitioner positive for symptom magnification and six out of seven Waddell signs. On examination Dr. Fletcher noted neurological deficits that included some right EHL weakness. Dr. Fletcher was of the opinion that smoking is an independent risk factor for degenerative disc disease. He further noted that petitioner had objective features of lumbar radiculopathy, but he disputed that they were related to her employment, and could be related to the stress on her lumbar fusion

at the level above this prior surgery. He did not believe that her condition was so disabling that she could not return to work. Dr. Fletcher did not believe that further chiropractic care was appropriate. He stated that if he was her treating physician he would consider a series of epidural steroid injections at L4 – L5, and if she failed to improve he would recommend a myelogram/CT to evaluate her anatomy since she had a prior fusion. He also indicated that he would consider doing electrical studies. Dr. Fletcher diagnosed status post surgical conditions related to the surgeries on 2/17/04, 6/30/04, 12/5/05, and 3/23/06. He also wanted to rule out a right L5 lumbar radiculopathy at L4- L5. Dr. Fletcher was of the opinion that barriers to resolution of petitioner's case included symptom magnification, her belief that her condition is disabling, nonoccupational injuries and medical conditions unrelated to this case, lengthy time in the patient role, a smoker, the condition, and disputed causation based on mechanism of injury. Dr. Fletcher opined that petitioner has incurred no permanent loss from her alleged work injury based on her mechanism of injury. He opined that permanent restrictions are not necessary. Dr. Fletcher opined that on 4/18/06 petitioner was at MMI from her two prior work injuries. He disputed causation with regards to her present condition of ill being.

On 1/28/08 petitioner underwent a functional capacity evaluation performed at Safe Works Illinois. The FCE summary noted a mixed client effort; five out of seven positive pain questionnaires for symptom magnification; present abnormal pain behaviors and test responses; that petitioner was capable of working at the medium physical demand level; and that the primary recommendations were for pain management and medical correlation.

On 2/22/08 petitioner returned to Dr. MacGregor following a new injury on 11/7/07. She indicated that over a two week period she was injured several times by a child on the bus. She indicated that he had been repeatedly kicking her and hitting her in the belly with his head. She complained that she could not walk for prolonged periods of time and gets aching in her legs and feet. She complained of numbness. She indicated that three toes on her right foot were intermittently numb. She complained of low back pain in her left leg with numbness intermittently. Prior to this she stated that she had been doing well, and was back to work full duty for over two years. Dr. MacGregor noted that the MRI dated 1/21/08 showed petitioner's prior fusion at the lumbosacral junction as well as some stenosis just above the level of her fusion secondary to a diffuse disc bulge and ligamentous hypertrophy. Also noted was some mild right neuroforaminal narrowing. Dr. MacGregor assessed a new injury at work after being injured by an eight-year-old child with behavioral problems. She recommended some Robaxin, physical therapy and epidural steroid injections. Petitioner was continued off work. Dr. MacGregor's

recommendations for physical therapy and injections were denied by workers compensation. On 3/20/08 Dr. MacGregor continued petitioner off work.

On 6/5/08 petitioner returned to Menard Medical Center complaining of pain in her lumbar area radiating down both legs. She also complained of increased pain with abduction of her legs. She stated that she can hardly get her grocery shopping done. She complained of numbness in her right foot in the first toe at times, and the second toe. Petitioner was assessed with lumbar pain and lumbar radiculopathy. Petitioner requested an out of network referral.

On 8/18/08 petitioner followed up with Dr. MacGregor and stated that she was okay as long as she did not overdo it. She stated that getting into a pool helps her legs. Dr. MacGregor changed her muscle relaxants to Skelaxin and added a Medrol Dosepak. She continued petitioner off work and referred her for lumbar epidural steroid injections. These injections were performed on 9/22/08 and 10/27/08. On 11/17/08 petitioner followed up with Dr. MacGregor and stated that she was still unable to take long walks and has difficulty sleeping. Dr. MacGregor recommended one additional epidural steroid injection. Petitioner stated that she was not yet willing to consider surgical intervention. Dr. MacGregor referred petitioner back to Dr. Meeks, her primary care physician, for discussion with respect to Chantix for tobacco cessation.

On 12/12/08 petitioner returned to Dr. MacGregor. She stated that she had two epidural steroid injections that gave her relief for about a week. She stated that she is unable to take long walks and has difficulty sleeping. Petitioner offered significant complaints of back pain but was reluctant to consider surgery as she was not sure it would make her better. Dr. MacGregor noted that petitioner continues to smoke. On review of the MRI of the lumbar spine performed in January 2008 Dr. MacGregor was of the opinion that it showed concentric moderate narrowing of the spinal canal due to a diffuse disc bulge and ligamentous hypertrophy at L4 – L5. She assessed lumbar disc degeneration and lumbar canal stenosis. Dr. MacGregor noted that petitioner was status post L5 – S1 posterior instrument stabilization and was doing well until she was involved in an altercation where a student kicked her in the back. Dr. MacGregor noted that since that time petitioner has had continued complaints with no relief with conservative treatment. Dr. MacGregor discussed an additional epidural steroid injection. She noted that petitioner was still not willing to consider surgical intervention. She referred petitioner back to Dr. Meeks for discussions with respect to Chantix for tobacco cessation.

On 1/6/09 petitioner returned to Dr. MacGregor and stated that she did not want to proceed with the recommended epidural steroid injection or take Chantix. Petitioner complained of intermittent low

back complaints. Petitioner stated that she might be interested in proceeding with surgical intervention. Dr. MacGregor stated that it would include an L4 – L5 decompression.

On 1/15/09 petitioner filed a motion for sanctions pursuant to sections 16, 19(k) and 19(l) of the Worker's Compensation Act. Petitioner claimed appropriate notice was given to the employer within 45 days of each accident. Petitioner claims that despite notice that she was off work by her treating physicians, and respondent refused to pay temporary total disability benefits during the period of time from 2/1/08 through 1/15/09. Petitioner further claims that petitioner failed to pay a bill from Springfield Clinic in the amount of $57,349.76 and a bill from Mason District Hospital in the amount of $3,024.00. Petitioner claims that such refusal to pay the temporary total disability and these unpaid bills was vexatious, unreasonable, and intentional. Petitioner attached a letter to respondent's attorney dated 12/14/07 providing details supporting the unpaid bills and requested for payment of the same. Attached to the petition was also a letter to respondent's attorney dated 11/17/08 including an off work slip dated 11/17/08 indicating that petitioner was unable to work until she was reevaluated on 12/29/08. Petitioner also indicated that respondent had not paid temporary total disability since 2/1/08.

On 2/20/09 petitioner returned to Dr. MacGregor. She stated that she had not made any progress with respect to tobacco cessation. She stated that she was going to undergo acupuncture treatment for smoking cessation. She stated that she was smoking one pack a day of cigarettes, down from 1 1/2 packs a day. She also indicated that she helped her husband cutting wood. She stated that she would roll the wood over to him in order for him to cut it. With respect to walking activities she stated that she walks through the timber. Dr. MacGregor reiterated that she cannot proceed with surgical recommendation until petitioner stops smoking. She authorized petitioner off work.

On 4/9/09 petitioner presented to Dr. MacGregor and stated that she had decreased her smoking to one pack per day. She stated that her pain medications and muscle relaxants were no longer working. Dr. MacGregor ordered a Medrol Dosepak to see if petitioner could get better control of her pain. She also renewed petitioner's Flexeril and Vicodin prescriptions. Petitioner was continued off work.

On 10/5/09 respondent's attorney sent a letter to petitioner's attorney confirming that respondent would not authorize any further medical treatment for petitioner due to the fact that petitioner did not suffer from a work-related condition.

On 10/16/09 petitioner underwent an MRI of the lumbar spine. The impression was degenerative changes with canal and foraminal stenosis at L4 – L5, postop changes at L5 – S1.

On 11/30/09 petitioner underwent a Section 12 examination performed by Dr. Soriano at the request of the respondent. Dr. Soriano performed a physical examination and record review. Dr. Soriano diagnosed status post soft tissue injury to the stomach and the low back based upon the alleged injury petitioner sustained over a two week period by a specific child. He opined that petitioner's prognosis was excellent, and her objective examination was completely within normal limits. On a subjective basis, he noted that her prognosis was guarded. Dr. Soriano was of the opinion that petitioner demonstrated evidence of symptom exaggeration, metastasizing pain complaints, pain, numbness and tingling complaints which have no relationship to any objective findings on radiologic studies or exam, and two positive Waddell signs which were strong procasticators for poor outcomes for surgery. Dr. Soriano recommended no further treatment and was of the opinion that petitioner could return to work without restrictions. Dr. Soriano opined that petitioner's subjective complaints regarding her back were not caused by any alleged work incident dating back as far as 2003. He was of the opinion that her natural history for an alleged soft tissue injury was incompatible with any known medical history of relatively minor soft tissue injuries. Dr. Soriano noted that no physician has ever documented abrasions, swelling, redness, spasm or bruises. On that basis, he was of the opinion that it is not likely, probable, or even possible that petitioner's current problems are related to any incident at work. He also noted that petitioner's radiological findings of circumferential stenosis on the basis of ligamentum hypertrophy, disc bulge, facet degeneration could not have been caused or aggravated by the prior alleged injuries. He opined that petitioner would not suffer any permanent impairment from this incident, and there is no causal connection to any other factors or activities outside of work for her current subjective complaints. Dr. Soriano was of the opinion that petitioner had reached maximum medical improvement within two weeks of the injury. He was of the opinion that reasonable treatment would have included work restrictions for two weeks, a 1 to 2 week period of chiropractic treatment or physical therapy, over-the-counter medications, and evaluation by her treating physician. He opined that epidural steroid injections and MRI scans were neither reasonable or necessary in relationship to the injury.

In January 2010 petitioner was scheduled to undergo the recommended surgery by Dr. MacGregor. However, since petitioner discontinued her beta blockers and her blood pressure increased, the surgery was canceled on 1/11/10. Dr. MacGregor noted that petitioner needed to be on the beta blockers for four weeks prior to surgery. Dr. MacGregor also noted that petitioner had not been compliant with her smoking cessation. Thereafter, petitioner called her primary care physician to get back on her blood pressure medicines.

On 2/1/10 petitioner followed up with Dr. MacGregor. She stated that she had cut back on smoking but had not yet quit. When queried further Dr. MacGregor noted that petitioner had not in fact cut back at all. Petitioner stated that she had got some orthotics for her shoes and had generally been feeling better. Petitioner reported that she wanted to discuss proceeding with a lumbar decompression versus a fusion. Dr. MacGregor did not recommend a decompression. She was of the opinion that petitioner would require a hardware fusion. Dr. MacGregor also spent a significant amount of time discussing tobacco cessation recommendations and told her that she would not proceed with the surgery until petitioner completely quit smoking.

On 3/11/10 petitioner returned to Dr. MacGregor. She stated that her pain was increasing and she really needed to get something done. She stated that she had been on Chantix and was down to one half pack of cigarettes on bad days. She stated that she cannot walk far because of the pain. Petitioner stated she believed that her symptoms warranted surgery regardless of whether or not she stops smoking. She stated that her husband's insurance was going to end on 4/30/10 and without insurance they would have to pay thousands of dollars out of pocket, which she could not afford. She stated that she continues to take Vicodin and Flexeril and remains off work. Dr. MacGregor again reiterated that petitioner will not be placed on the surgery schedule until she is done smoking. She also discussed the importance of petitioner remaining smoke-free following surgery to improve the likelihood effusion.

On 5/13/10 petitioner returned to Dr. MacGregor and complained of a lot of burning sensation on the right side. Petitioner stated that she was still on Chantix and was down from 10 packs of cigarettes a week to three. Dr. MacGregor encouraged petitioner to try and walk as much as possible and to continue her daily stretches. She reiterated the criteria for proceeding with the surgery. She continued petitioner off work.

Petitioner followed up with Dr. MacGregor on 6/21/10 and 8/16/10. Petitioner's condition remained essentially unchanged on these visits. On 8/16/10 Dr. MacGregor stated that petitioner would need a new MRI before surgery could proceed. However, she stated that she would not be proceeding with the new MRI until petitioner completely quit smoking. Petitioner was continued off work. On 10/18/10 petitioner's visit to Dr. MacGregor was essentially the same. Petitioner was continued off work. New updated imaging was not ordered.

Petitioner also continued to follow up at Menard Medical Center for her low back pain and the fact that petitioner would not be able to proceed with the recommended back surgery until she quit smoking. On 12/17/10 petitioner stated that she is going to start to commit to lozenges to stop smoking.

On 12/13/10 petitioner followed up with Dr. MacGregor. At that visit Dr. MacGregor personally phoned Dr. Thompson and spoke to her regarding petitioner's off work status. Dr. MacGregor explained that petitioner was still smoking and that she would not proceed with any further testing for surgery, since petitioner was not a surgical candidate while she was smoking. Dr. MacGregor asked that Dr. Thompson take over petitioner's off work status and pain medications. Dr. Thompson agreed stating that petitioner either quit smoking or she is going back to work. No follow-up appointments were scheduled.

On 2/18/11 petitioner followed up with Dr. Woodson. Dr. Woodson noted good recovery of local function and healing of the vocal folds. She noted that petitioner still has some interarytenoid pachydermia related to reflux. She recommended that petitioner follow-up every couple years.

On 5/20/11, 10/14/11, and 12/5/11 petitioner followed up with Dr. Thompson. Petitioner reported that she was still in pain and was getting worse. Dr. Thompson reiterated that she was not eligible for back surgery until she quit smoking. On 10/24/11 an x-ray of the cervical spine showed postsurgical changes, and good alignment. An MRI of the cervical spine performed 10/28/11 revealed degenerative changes with disc at C6 – C7 compromising left neural foreman. Mild diffuse degenerative changes were also noted.

On 11/7/11 petitioner presented to Dr. Watson for her neck pain that she had for the past several months. She denied any fall or injury that might of cause the pain. She rated her pain at a 10/10. Dr. Watson assessed cervical degenerative disc disease, multilevel, status post cervical fusion at C5-C6, and cervical facet arthropathy with questionable cervical radiculopathy. Dr. Watson was of the opinion that petitioner's symptoms were mild and he did not see anything on the MRI that would necessitate any type of surgical intervention. He recommended a focused cervical rehabilitation program working on range of motion and strengthening exercises.

On 1/5/12 petitioner presented to Dr. Espinosa for neck pain. Following an examination Dr. Espinosa assessed pain in the distribution of the greater occipital nerve. He referred petitioner to the pain clinic for an occipital nerve block.

Petitioner continued to follow up with Dr. Thompson. On 4/16/12 Dr. Thompson completed a medical source statement concerning the nature and severity of petitioner's physical impairment. She noted that petitioner had a long and complicated history of both lumbar and cervical spine disease. She stated that her problems began in 2003 after an injury when a school bus and large truck collided. She detailed petitioner's treatment and noted that petitioner has been unable to undergo the lumbar

decompression recommended by Dr. MacGregor because she remains a smoker. She stated that most recently petitioner was diagnosed with cervical radiculopathy and epidural injections were recommended.

On 5/12/12 Dr. Thompson drafted a letter clarifying previous off work notes. She noted that on 1/6/05 petitioner was unable to return to work due to lack of position for restricted work. She further wrote that on 7/7/05 petitioner was released to work by Dr. MacGregor, and on 8/10/06 petitioner was released to work by Dr. Woodson. On 8/27/12, 2/25/13, and 5/20/13, petitioner followed up with Dr. Thompson and the condition remained essentially unchanged. Dr. Thompson again reiterated that the surgery recommended by Dr. MacGregor could not be performed until petitioner stopped smoking, and that petitioner had not stopped smoking.

On 12/18/12 the evidence deposition of Dr. Thompson was taken on behalf of petitioner. Dr. Thompson testified that the first time she saw petitioner was on 12/2/10 for pneumonia. Dr. Thompson opined that the neck and low back pain for which she treated petitioner could have been related to her work accident on 1/31/03 and 11/7/07. She further stated that the symptoms petitioner had on 8/27/12 could also be related to the same accident. Dr. Thompson was of the opinion that petitioner was not at maximum medical improvement since she opted to have the surgery. She further opined that the pain petitioner was experiencing in her legs and feet the last time she saw her could be related to the accidents of 1/31/03 and 11/7/07, and the accidents of 1/31/03 and 11/7/07 could have made petitioner's spinal stenosis worse. Dr. Thompson was of the opinion that petitioner's condition, with respect to her low back and neck, could be permanent if she has no further treatment.

On cross examination Dr. Thompson opined that spinal stenosis can be acquired in multiple ways and smoking can accelerate the progressive nature of that disease. Dr. Thompson testified that petitioner told her that she was unsure if she wanted to quit smoking or undergo the recommended surgery. Dr. Thompson opined that complaints of upper neck pain radiating into the right arm as of 10/3/02 could be consistent with the onset of spinal stenosis in her neck, and complaints of severe low back pain radiating into the legs on occasion could also be consistent with the onset of stenosis in the lumbar spine. On redirect examination Dr. Thompson then opined that even if petitioner had an onset of stenosis on the dates, that the accident on 1/31/03 and 11/7/07 could have aggravated or accelerated the pre-existing stenosis.

On 4/15/13 Matthew Brue, Superintendent for respondent, sent petitioner a letter stating that they had recently learned that she had formally retired in the IMRF system, but did not notify respondent of her decision to retire. She was reminded that the PORTA District does not pay for retired member

insurance premiums. She was informed that her premiums would be paid through 5/31/13, and that she would be eligible for COBRA benefits.

On 6/19/13 the evidence deposition of Dr. Margaret MacGregor was taken on behalf of the petitioner. Dr. MacGregor testified that she was initially asked to examine petitioner on behalf of respondent and petitioner asked her to become her treating doctor. Dr. MacGregor opined that when the student attacked petitioner on 11/7/07 that attack could have made petitioner's degenerative level symptomatic, and her symptoms at that time were consistent with that. Dr. MacGregor testified that the only way she would perform surgery on petitioner was if her nicotine level was zero and petitioner was willing to contractually sign that she will not go back to smoking. Dr. MacGregor opined that the recommended surgical intervention, because of the listhesis involved, could be attributed to the different accidents that petitioner sustained. Dr. MacGregor opined that given the history petitioner provided, the incidents petitioner described were sufficient to cause the condition for which Dr. MacGregor treated petitioner, and could have also caused or contributed to her condition as a whole. Dr. MacGregor was of the opinion that petitioner has delayed her own treatment by her continued smoking, and this is going to affect the level of function and degree of disability, as would her self-limiting pain behavior. She stated that petitioner's now older, is more deconditioned, and likely has more medical problems. She testified that she would attribute some of the limitations and symptoms petitioner was currently having to the problems that may have been caused or aggravated by her three accidents.

On cross-examination Dr. MacGregor opined that smoking leads to increased problems in the spine that include disc degeneration and deterioration of the petitioners bone density. Dr. MacGregor testified that at this point in time petitioner has chosen smoking over additional treatment and care. On redirect examination, Dr. MacGregor opined that despite the effect that smoking may have had on petitioner spine, she continues to opine that the three accidents petitioner sustained caused or contributed to petitioner's problems in her cervical and lumbar spine and the treatment she provided. She further opined that the necessity for the surgery that has been postponed is also related in part to the accident petitioner sustained.

On 8/15/13 the evidence deposition of Dr. Soriano, a neurosurgeon, was taken on behalf of the respondent. Dr. Soriano opined that smokers have a much higher rate of chronic low back pain and have a much higher, much longer healing rate for any soft tissue back injury, up to 30% longer.

On cross-examination Dr. Soriano testified that he did not offer any conclusions about any accident other than the one on 11/7/07. Dr. Soriano was of the opinion that petitioner's regular duty job was light duty.

Petitioner began treating with Dr. Bilyeu. On 2/28/14 Dr. Bilyeu also noted that petitioner has chronic pain in her back and neck. He advised petitioner to stop smoking and get back with her surgeon to see what else could be done.

On 4/4/14 the evidence deposition of Dr. Woodson was taken on behalf of the petitioner. Dr. Woodson was of the opinion that the problems petitioner had with her throat started after her cervical surgery and could not heal because of her underlying problems. Dr. Woodson opined that the use of the intubation tube during surgery is when the whole process started, and then other conditions, such as acid reflux and speaking a lot in her work environment, may have aggravated the condition. Dr. Woodson opined the treatment he provided was at least in part related to the damage caused by the use of the intubation tube during the cervical surgery.

On cross-examination Dr. Woodson opined that if petitioner never had the problems prior to her intubation, then it is most likely that the problems were the result of the intubation. Dr. Woodson stated that he had no information that from March 2004 through July of 2005 that petitioner complained to any of her treaters of any symptoms, and that when she again had complaints they were of a different sensation, including a lump in her throat in July 2005. Based on this finding he was of the opinion that it is possible that the burning sensation petitioner experienced in March 2004 could have been a temporary problem that went away, and the problems she experienced in July 2005 could have been a different problems including her reflux and other environmental factors. Dr. Woodson opined that petitioner's current complaints and findings could be the result of her intubation, reflux, smoking, or some swelling. Dr. Woodson opined that the swelling in the throat could get to the point where it feels like a lump in the throat.

On redirect examination Dr. Woodson opined that during her spine surgery petitioner had a tube in her throat that was manipulated during the surgery. She stated this manipulation would cause some disruption and it is very likely that that could lead to her symptoms. She further opined that even though that surgery may not have been the sole cause of her ongoing symptoms it was at least a contributing factor.

On 6/19/14 petitioner's diagnoses included current smoker, cervical radiculopathy, headache, lumbar disc degeneration, lumbago, lumbar radiculopathy, lumbar canal stenosis, chronic pain, and tobacco dependence.

On 8/25/14 respondent offered into evidence a Subrogation Notice to petitioner from Illinois Department of Healthcare and Family Services regarding the accident on 11/7/07.

On 2/10/85 petitioner sustained an alleged accident to her back. She filed case 05 WC 82390 for this claim. This claim was settled, and approved on 11/10/86 for 2.5% Man as a Whole, or $1,523.25.

On 8/15/00 petitioner underwent a HCNA multi-system examination. With respect to her cervical spine petitioner demonstrated full range of motion, tracheal midline position, and no thyromegaly. She was released on an as needed basis with no restrictions.

On 4/9/01 petitioner reported back pain after lifting an entertainment center. She felt a sharp pull and pulling sensation on the right side. On 12/6/01 petitioner complained of pain that sometimes starts in her back and radiates to her right upper extremity. She was assessed with thoracic back pain.

On 1/8/02 petitioner called Menard Medical Center and reported that she was out of acid reflux medication and had a few episodes. She was prescribed Nexium.

On 10/3/02 petitioner complained of upper neck pain and pain radiating down her arm. On 12/20/02 petitioner complained of right shoulder and elbow pain after being bounced around in the back of the bus and braced her arm against the seat.

Respondent offered into evidence payment sheets that reflect medical payments of $73,595.86, and Indemnity payments of $27,541.26.

Petitioner testified that both prior to and after the three accidents on 1/10/03, 1/31/03 and 11/7/07 she has tried many different options in an attempt to stop smoking without any lasting success. She testified that she has tried patches, Chantix, hypnosis, and ear injections. As of 10/15/14 petitioner testified that she was still smoking and has been unable to stop.

Currently, petitioner testified that she does not feel good. She stated she needs to alternate positions because of numbness and pain if she does not move and adjust herself. She stated that as of July 2014 she could walk 4 1/2 minutes. Petitioner testified that she wants the surgery, but is still smoking. Petitioner testified that the surgery to her neck was paid for by Workers' Compensation.

On cross examination petitioner admitted that in December of 2001 she presented with back pain and radiating pain, and in October of 2002 reported neck pain, headaches, and pain down her arm. Petitioner testified that she has not looked for work, or applied for any work. She testified that she has taken herself out of the labor market and has not tried to return to any type of work. Petitioner testified that she has swam in her pool per Dr. MacGregor's recommendations, and watches her older grand children. Petitioner testified that she has had problems with heartburn before January 2013.

F. IS PETITIONER'S CURRENT CONDITION OF ILL-BEING CAUSALLY RELATED TO THE INJURY?

It is unrebutted that petitioner sustained an accidental injury that arose out of and in the course of her employment by respondent on 1/10/03, 1/31/03 and 11/7/07.

With respect to the injury on 1/10/03 petitioner sustained an injury to her low back. On examination she complained of severe left sided low back pain radiating to her legs on occasion. She denied any numbness or tingling. She noted tenderness over the L5-S1 joint. Petitioner was assessed with low back pain. She was authorized off work until 1/21/03. When petitioner returned to work on 1/21/03 she testified that she was doing good. Petitioner worked without incident until the injury on 1/10/03. Based on this evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to her low back is not causally related to the injury she sustained on 1/10/03.

With respect to the injury on 1/31/03 petitioner sustained an injury to her low back and cervical spine. As a result of that injury, and following conservative treatment that did not result in any lasting improvement, petitioner underwent an anterior cervical decompression and fusion with arthrodesis, introduction of 8 mm lordotic interbody spacer, and plating from C5 - C6. This procedure was performed by Dr. MacGregor. Petitioner's postoperative diagnosis was C4-C5 herniated disc. On 6/30/04 petitioner also underwent a lumbar vertebral fusion, arthrodesis of the lumbar spine by posterior interbody technique, spinal instrumentation posterior non-segmental, and neurological surgery laminectomy. This procedure was performed by Dr. MacGregor and Dr. Pineda. Petitioner's postoperative diagnosis was degenerative disc disease at L5-S1.

Post operatively petitioner followed up with Dr. MacGregor for her cervical condition and with Dr. McGregor and Dr. Pineda for her lumbar condition. Petitioner testified that at the time of these surgeries and for many years prior she smoked a pack of cigarettes a day. On 11/15/04 petitioner complained of pain in her neck. She also had ongoing low back complaints. At that time Dr. MacGregor was of the opinion that petitioner was anticipated to reach maximum medical improvement with respect to her cervical spine by February 2005, and for lumbar spine by June 2005. However on 2/14/05 petitioner was

still complaining of some residual complaints following her surgery. Petitioner underwent an FCE in June 2005. It was determined that petitioner was not able to return to her regular duty job at that time.

On 7/7/05 petitioner reported that she had a feeling of a lump in her throat, and intermittent pain in the left ankle and sometimes both legs. This was the first documented complaint of a feeling of a lump in her throat following the surgery in February of 2004. Dr. MacGregor released petitioner to full duty work on 7/11/05 and was of the opinion that petitioner had reached maximum medical improvement.

On 8/26/05 petitioner presented to Dr. Aldridge for the feeling that something was stuck in her throat. Petitioner reported that this problem had been present since her surgery. She also complained of hoarseness.

Petitioner began treating for her throat problems with Dr. Woodson on 9/9/05. She admitted that she did have a history of acid reflux for which she took medications. Dr. Woodson performed surgery on petitioner's throat and assessed laryngipharyngeal reflux, and leukoplaxia. Petitioner underwent a 2nd surgical procedure by Dr. Woodson on 3/23/06 where he excised some vocal cord lesions. On 5/1/06 Dr. Woodson performed another procedure that revealed left true vocal cord hyperkeratosis, left false cord papilloma, and gastroesophageal reflux disease with associated laryngopharyngeal reflux. For these symptoms petitioner treated with Dr. Syed. She reported discomfort when she swallows solid food, and this problem did not occur until after her cervical spine surgery. Based on these complaints Dr. Syed ordered a colonoscopy. He noted no significant evidence of reflux esophagitis and noted that there had not been any improvement in her symptoms since taking Nexium and Zantac. For these reasons he stopped these medications.

On 8/10/06 petitioner saw Dr. Aziz for her ongoing throat problems. He opined that petitioner had scarring on her vocal cord, and her hoarseness may not improve given this scarring.

Dr. Woodson opined that petitioner's symptoms did not occur until after her cervical spinal surgery in February 2004 and could not heal because of her underlying problems. She was of the opinion that the use of the intubation tube during surgery is when the whole process started and then the other conditions, such as acid reflux and speaking alot in her work environment, may have aggravated the condition. She opined that the treatment she provided petitioner was at least in part related to the damage caused by the use of the intubation tube during the cervical surgery. She opined that the preexisting problem had been exacerbated by the surgery, and healing was prevented by her preexisting extraesophageal acid reflux disease, and the strain on her voice was due to the need to speak loudly over a noisy environment. She

opined that the level of speech required by her job caused further damage to her injured larnyx. Dr. Woodson opined that since petitioner never had this problem prior to the intubation then it was most likely that her current problems were the result of the intubation. Dr. Woodson admitted that the problems petitioner experienced in July of 2005 could have been different problems including her reflux and other environmental problems. However, the arbitrator finds that since petitioner reported to Dr. Syed that the medications she was taking for acid reflux were not helping her condition, that the acid reflux was not causing petitioner's problems.

Dr. Woodson opined that during petitioner's surgery she did have a tube in her throat that was manipulated during the surgery. She was of the opinion that this manipulation would cause some disruption and could very likely lead to her symptoms. She opined that even though the surgery may not have been the sole cause of her ongoing symptoms, it was at least a contributing factor.

Dr. Fletcher offered a different opinion. He opined that there was no causal connection between petitioner's cervical fusion and her ENT problems that required surgery on 3/23/06. He noted that petitioner was a smoker, has reflux, which along with smoking is another risk factor for the development of laryngeal problems, especially hoarseness. He was of the opinion that while a person can develop a complication of her cervical fusion and injury to the laryngeal nerve, these patients develop hoarseness soon after surgery. He was of the opinion that since petitioner did not have any documented complaints until 15 months after her surgery, that it cannot be related. The arbitrator finds it significant that even though petitioner did not seek treatment until 15 months after the surgery she reported that the symptoms she complained of at that time had been present since the cervical fusion.

Based on the above, as well as the credible evidence, the arbitrator finds the opinions of Dr. Woodson more persuasive than those of Dr. Fletcher as it relates to petitioner's current condition of ill-being related to her hoarseness and lump in her throat. The arbitrator finds Dr. Woodson's opinions more persuasive given the fact that although petitioner admitted that she had acid reflux and smoked prior to the cervical surgery in 2004 she never had any problems with respect to a swelling feeling in her throat and hoarseness. It was not until after this surgery that petitioner testified she started having problems, albeit she did not seek treatment for them until 15 months later. The arbitrator finds Dr. Woodson's opinion that although the intubation associated with the surgery may not have been the sole cause of her ongoing symptoms, it was at least a contributing factor, more persuasive that Dr. Fletcher's opinion that there could be no causal relationship, especially in light of Dr. Syed's opinion that the Nexium and Zantac

were not helping her, thus minimizing somewhat the relationship between petitioner's acid reflux and her current hoarseness and lump in her throat.

Following the accident on 1/31/03 petitioner underwent surgery to her cervical spine and lumbar spine that consisted of a cervical fusion and lumbar fusion. Post-operatively petitioner followed up with Dr. MacGregor and Dr. Pineda. Following an FCE in June of 2005 that determined petitioner could safely attempt to return to her regular job, Dr. MacGregor released petitioner to full duty work as it relates to her cervical and lumbar fusions. Thereafter, until the accident in November of 2007, petitioner only followed up once with Dr. MacGregor in 6/15/06 and reported intermittent problems with her low back and leg pain. Petitioner stated that she was able to live with her current complaints.

Dr. Fletcher opined that there was no causal connection between petitioner's current condition of ill-being as it relates to her low back and the accident on 1/31/03 based on a significant gap between the accident and her fusion in June of 2004. The arbitrator finds this opinion is not supported by the credible medical record since just days after the accident, on 2/3/03 petitioner complained of low back pain. On 2/10/03 she complained of more low back pain. On 3/14/03 she complained of thoracic pain. On 4/14/03 she complained of pain down her left leg and trouble walking. On 4/25/03 she complained of low back pain. On 7/17/03 her low back complaints continued. An MRI of the lumbar spine was performed on 8/12/03. An EMG was performed on 9/24/03. Thereafter, petitioner underwent epidural steroid injections for her low back, and continued treating until the surgery in June 2004. With respect to her cervical fusion Dr. Fletcher just opined that it was not reasonable and necessary and not causally related to the injury on 1/31/03.

With respect to petitioner's cervical and low back condition as it relates to the accident on 1/31/03, Dr. Thompson opined that the neck and low back pain for which she treated petitioner could have been related to her work accident on 1/31/03. She further opined that even if petitioner had an onset of spinal stenosis before the 1/31/03 the accident on that date could have aggravated or accelerated the preexisting stenosis.

Dr. MacGregor, who was initially respondent's examining physician, became petitioner's treating physician. Dr. MacGregor opined that the accident petitioner sustained on 1/31/03 caused or contributed to petitioner's problems in her cervical and lumbar spine.

Based on the above, the arbitrator adopts the opinions of Dr. MacGregor and Dr. Thompson over those of Dr. Fletcher as it relates to the causal connection between petitioner's lumbar spine and cervical

spine and the accident on 1/31/03, and finds petitioner's current condition of ill-being as it relates to her cervical spine and lumbar spine are causally related to the accident petitioner sustained on 1/31/03. However, the arbitrator finds the causal connection between petitioner's lumbar spine condition and the accident on 1/31/03 ended on 11/7/07 when petitioner sustained an intervening accident to her lumbar spine. The arbitrator bases this opinion on the fact that Dr. Fletcher's opinions are based on an incorrect understanding of petitioner's accident history and her treatment following the incident. The arbitrator finds the opinions of Dr. MacGregor most persuasive given her accurate understanding of the accident and the fact that she was petitioner's treating physician following the accident.

Lastly, with respect to the causal connection between petitioner's current condition of ill-being as it relates to petitioner's lumbar spine and the accident on 11/7/07. The arbitrator looks to the treating records and opinions of Dr. MacGregor and Dr. Thompson, as well as the opinions of Dr. Soriano and Dr. Fletcher.

Following the undisputed accident on or about 11/7/07, where petitioner was punched and kicked in her stomach and lumbar spine, petitioner sustained an exacerbation of her lumbar spine condition. Petitioner had ongoing complaints of low back pain. She underwent an MRI of the lumbar spine that revealed moderate degenerative changes at the level of the L4-L5 just above the fusion.

Dr. Soriano opined that petitioner's subjective complaints were regarding her low back were not caused by any alleged work incident dating as far back as 2003. Dr. Soriano was of the opinion that petitioner only sustained soft tissue injuries as a result of the incident on 11/7/07, and therefore her current condition of ill-being as it relates to her lumbar spine is not causally related to the accident on 11/7/07.

Dr. Fletcher noted neurological deficits that included some right EHL weakness, and objective features of lumbar radiculopathy, but disputed that they were related to her employment. This opinion was based in part on symptom magnification he noted during his examination.

Dr. MacGregor opined that petitioner was doing well post lumbar fusion until she was kicked in the back by a student, and has had ongoing complaints since then with no relief from conservative treatment. Dr. MacGregor opined that the attack on petitioner could have made her degenerative level symptomatic.

Dr. Thompson opined that the low back pain for which she treated petitioner could have been related to her work accident on 11/7/07. She further opined that even if petitioner had an onset of spinal stenosis of 1/31/03 the accident on that date could have aggravated or accelerated the preexisting stenosis.

Based on the above, the arbitrator adopts the opinions of Dr. MacGregor and finds the petitioner's current condition of ill-being as it relates to her lumbar spine is casually related to the injury she sustained on 11/7/07. The arbitrator finds the opinions of Dr. MacGregor more persuasive given the fact that Dr. MacGregor has been petitioner's treating physician since 2003 and has the best understanding of petitioner's lumbar spine condition since that time. The arbitrator also finds it significant that following petitioner's lumbar surgery on 2004, petitioner was ultimately returned to full duty work on 7/11/05 and found to have reached maximum medical improvement. For the next 2+ years petitioner worked her full duty job with only intermittent complaints. Then after the accident on 11/7/07 petitioner had a significant increase in her lumbar back pain that was ongoing, prevented her from performing her regular duty job, and resulted in the recommendation of an additional lumbar surgery due to an exacerbation of her pre-existing condition.

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?

Having found petitioner's cervical spine, lumbar spine and throat conditions causally related to the accidents petitioner sustained on 1/10/03, 1/31/03, and 11/7/07, the arbitrator finds the treatment petitioner received for these conditions was reasonable and necessary to cure or relieve petitioner from the effects of the injuries she sustained on 1/10/03, 1/31/03 and 11/7/07.

The arbitrator finds the respondent shall pay for all medical services petitioner received from 1/10/03 through 10/15/14, pursuant to Section 8(a) and Section 8.2 of the Act, including the treatment associated with petitioner's smoking cessation efforts.

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.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner's cervical spine, lumbar spine and throat condition causally related to the accidents petitioner sustained on 1/10/03, 1/31/03, and 11/7/07, the arbitrator finds the lumbar fusion recommended by Dr. MacGregor is reasonable and necessary to cure or relieve petitioner from the effects of the injuries she sustained on 11/7/07.

However, the arbitrator finds it significant that petitioner has failed to stopped smoking and has been untruthful to Dr. MacGregor about her efforts, and Dr. MacGregor has indicated that she will not perform the surgery until the petitioner has stopped smoking, her nicotene level is zero, and petitioner signs a contract indicating that she will not go back to smoking. the arbitrator also finds it significant that Dr. MacGregor stated that she would not perform the recommended surgery until additionally testing was performed that confirmed this surgery was still necessary. Dr. MacGregor stated that this testing will not be performed until the petitioner's nicotene level is zero, and petitioner signs a contract indicating that she will not go back to smoking.

Therefore, the arbitrator finds the petitioner's request for surgery at this time is not reasonable and necessary and is premature.

L. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner claims she is entitled to temporary total disability benefits from 1/17/03 through 1/29/03 for the accident on 1/10/03; 1/31/03 through 8/10/05 for the accident on 1/31/03, and 11/7/07 to 10/15/14 for the accident on 11/7/07. Respondent claims petitioner is entitled to no temporary total disability benefits for the accident on 1/10/03; is entitled to temporary total disability benefits from 2/3/03 through 7/18/05 for the accident on 1/31/03, and 11/10/07 through 1/28/08, and 10/7/09, for the accident on 11/7/07.

Having found the petitioner's cervical spine, lumbar spine and throat condition causally related to the accidents petitioner sustained on 1/10/03, 1/31/03, and 11/7/07, the arbitrator finds the petitioner was temporarily totally disabled from 1/13/03 through 1/20/03 for the accident on 1/10/03 based on the records of Dr. Redding. The arbitrator also finds the petitioner was temporarily totally disabled from 2/3/03 through 7/18/05 for the accident on 1/31/03 based on the treating records of Dr. Redding and Dr. MacGregor. With respect to the accident on 11/7/07 the arbitrator finds the petitioner was temporarily totally disabled from 11/10/07 through 2/1/10, the date Dr. MacGregor told petitioner that she would not proceed with surgery until petitioner completely quit smoking. The arbitrator finds this date is significant since on this date petitioner told Dr. MacGregor that she had cut back on smoking, but after further query petitioner stated that she had not cut back at all. From this point on Dr. MacGregor opined that there was nothing further she could do for petitioner until petitioner stopped smoking. The arbitrator finds that from this date to the date of trial, the only reason Dr. MacGregor could no longer proceed with petitioner's treatment was because petitioner had refused to stop smoking, and had not been truthful with respect to her smoking cessation efforts. The arbitrator finds petitioner's decision to not stop smoking is

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

☒ 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

Judi Hartman,
Petitioner,

vs. NO: 13 WC 36357

15IWCC0635

Country Financial,
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 sole issue of the nature and extent of Petitioner's permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 17, 2015, is hereby affirmed and adopted.

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

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

15IWCC0635

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 20 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/05/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARTMAN, JUDI
Employee/Petitioner

Case# **13WC036357**

COUNTRY FINANCIAL
Employer/Respondent

15IWCC0635

On 2/17/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4707 LAW OFFICE OF CHRIS DOSCOTCH
2708 N KNOXVILLE AVE
PEORIA, IL 61604

2904 HENNESSY & ROACH PC
STEPHEN J KLYCZEK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

STATE OF ILLINOIS)
)SS.
COUNTY OF MC CLEAN)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Judi Hartman
Employee/Petitioner

Case # **13** WC **36357**

v.

Country Financial
Employer/Respondent

15IWCC0635

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **January 23, 2015**. By stipulation, the parties agree:

On the date of accident, **April 9, 2012**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**39,861.12**, and the average weekly wage was $**766.56**.

At the time of injury, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

All appropriate Temporary Total Disability benefits have been paid to Petitioner.

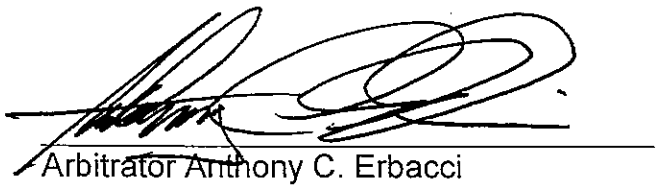
After reviewing all of the evidence presented, the Arbitrator hereby makes findings and conclusions regarding the nature and extent of the injury, and attaches those findings and conclusions to this document.

ORDER

Respondent shall pay Petitioner the sum of $**459.94**/week for a further period of **113.85** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **45% disability to the Petitioner's right arm**.

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

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



Arbitrator Anthony C. Erbacci

February 9, 2015
Date

FEB 17 2015

FACTS:

On April 9, 2012 the Petitioner sustained undisputed accidental injuries arising out of and in the course of her employment with the Respondent. The Petitioner was employed by the Respondent as an accounting specialist which the Petitioner described as a sedentary desk job that required her to work on a computer most of the work day. The Petitioner testified that she is right hand dominant.

The Petitioner testified and the medical records demonstrate that she was injured on April 9, 2012 when she stepped into a defect in the employee parking and she tripped and fell striking her right elbow on the ground. The Petitioner was immediately transported from the scene of her injury to Advocate BroMenn Hospital where she was hospitalized for 4 days. Orthopedic specialist Dr. Kolb was called in for surgical consultation and evaluation.

On April 10, 2012 Dr. Kolb performed a right elbow open reduction internal fixation of a comminuted intra-articular distal humerus fracture utilizing screws and plates. Dr. Kolb placed 2 plates on the Petitioner's humerus and one over the olecranon. Dr. Kolb also performed an anterior ulnar nerve transposition. The post-operative diagnosis was comminuted right elbow distal humerus fracture.

Due to continued complications from the initial injury, Dr. Kolb referred the Petitioner to Dr. Mark Cohen at Midwest Orthopaedics. Dr. Cohen performed surgery on the Petitioner's right arm on June 13, 2013. Dr. Cohen's surgery consisted of a radical right elbow release and debridement with resection of heterotopic bone, implant removal right elbow and triceps tenolysis through a separate facial plane. Dr. Cohen's operative finding was post traumatic arthritis, retained elbow and significant capsular contracture with bony and soft tissue impingement.

On September 12, 2013 Dr. Kolb performed a third surgery on the Petitioner's right arm to remove the right elbow olecranon plate and screws. Dr. Kolb ultimately released the Petitioner to return to her regular work duties on December 11, 2013. Prior to her final orthopedic visit, the Petitioner was evaluated in physical therapy and noted to have had good relief of pain but significant limitations in motion, stiffness and strength in her right upper extremity. The physical therapist progress note of December 10, 2013 noted limitations with reaching carrying and throwing and abnormal flexion, extension and supination. The therapist also documented a loss of grip strength in the Petitioner's right hand as compared to that in her left hand. When Dr. Kolb last evaluated the Petitioner he also noted loss of motion, flexion, extension, pronation and supination.

At the request of the Respondent Petitioner was examined by Dr. Balaram on August 5, 2014. Dr. Balaram noted that the Petitioner continued to have pain and residual numbness and tingling in her small and ring fingers as well as a loss of range of motion in her right elbow. Dr. Balaram's physical examination demonstrated that the Petitioner had lost some additional range of motion since her last examination with Dr. Kolb in December 2013.

The December 15, 2014 deposition testimony of Dr. Cohen was admitted into the record as Petitioner's Exhibit 7. Dr. Cohen testified regarding the surgery he performed, his operative findings, and the Petitioner's prognosis for the future. Dr. Cohen testified that while it was entirely speculative, his opinion was that, more likely than not, the will need an elbow arthroplasty at some point in the future.

The December 17, 2014 deposition testimony of Dr. Balaram was admitted into the record as Respondent's Exhibit 1. Dr. Balaram testified that his diagnosis of the Petitioner was right comminuted intra-articular distal humerus fracture with post traumatic arthritis and right elbow arthrofibrosis. Dr. Balaram opined that the Petitioner had, overall, a 20 to 25% loss of range of motion in her right elbow. Dr. Blaram testified that, as of the date he examined the Petitioner, the Petitioner was not in need of any further medical treatment. Dr. Balaram further testified that it would be entirely speculative to render any opinion as to what, if any, future medical treatment would be necessary for the Petitioner. Dr. Balaram testified that he performed an impairment evaluation pursuant to the AMA guidelines and that the Petitioner's upper extremity impairment rating was 10% and the whole person impairment was 6%.

The Petitioner testified that her condition has continued to worsen and that she experiences pain on a daily basis. The Petitioner testified that activities aggravate her pain level. The Petitioner testified that she also continues to experience intermittent numbness and tingling in her 4th and 5th fingers, mostly at the end of the work week. The Petitioner testified that her right elbow is extremely sensitive to touch and that if she bumps her elbow she experiences very severe pain.

The Petitioner also testified that she has very limited motion in her right elbow and that she is unable to straighten her arm. She testified that she also has to involve her shoulder in order to rotate her arm from side to side. The Petitioner demonstrated her range of motion at the time of hearing and the Arbitrator observed that the Petitioner was only able to minimally rotate her arm without involvement of the shoulder. The Arbitrator also observed that the Petitioner is unable to straighten her arm.

The Petitioner further testified that she has lost strength in her right arm and now relies on her left arm for heavier lifting. The Petitioner also testified that she is unable to do some activities of daily living, or has to modify those activities, due to her elbow injury. The Petitioner testified to difficulties with blow drying her hair, going to the bathroom, dressing herself and performing household chores due to her injuries.

The Petitioner testified that she is able to perform her job duties and that she can work 1 to 1 ½ hours before having to rest. She testified that after 1 ½ hours of work she notices an increase in symptoms and stiffness in her elbow and she has to take a break. The Petitioner continues to work her regular job without any formal job restrictions and she has not experienced a decrease in earnings as a result of her injury.

The sole issue in dispute in this matter is the nature and extent of the Petitioner's injuries.

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

The Petitioner's undisputed work accident occurred after September 1, 2011. Therefore, Section 8.1(b) of the Act requires consideration of the following criteria in determining the level of permanent partial disability:

* The level of impairment reported by a physician licensed to practice medicine in all of its branches based upon the most current edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment.

* the occupation of the injured employee:

* the age of the employee at the time of the injury;

* the employee's future earning capacity; and

* evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability but the relevance and the weight of any factors used in addition to the level of impairment as reported by the physician must be explained.

In the instant case, the Petitioner suffered

With regard to the reported level of impairment pursuant to Section 8.1(b), the level of impairment reported by Dr. Balaram pursuant to the American Medical Association's Guides to Evaluation of Permanent Impairment is upper extremity impairment of 10% and whole person impairment of 6%. The Arbitrator notes that impairment does not equate to permanent partial disability under the Workers' Compensation Act.

With regard to the occupation of the injured employee, the Petitioner's occupation is that of finance account specialist which requires sedentary level work at a computer. The Arbitrator concludes that the Petitioner's ability to perform the duties of her employment will be somewhat adversely affected by her permanent partial disability as she is required to use a computer all day and must use her right hand to do so.

With regard to the age of the employee at the time of injury, the Petitioner's age at the time of injury was 55 years old. The Arbitrator considers the Petitioner to be a younger individual and concludes that the Petitioner's permanent partial disability will be more extensive than that of an older individual because she will have to live with the permanent partial disability longer.

15IWCC0635

With regards to the employee's future earning capacity, the Arbitrator notes that there was no evidence presented which indicates that the Petitioner's future earning capacity will be affected in any way by her injury.

With regard to the evidence of disability corroborated by the treating medical records, the Petitioner credibly testified that she currently experiences pain in her right arm as well as intermittent numbness and tingling in her 4th and 5th fingers. The Petitioner also testified that she has very limited motion in her right elbow and that she is unable to straighten her arm. She testified that she also has to involve her shoulder in order to rotate her arm from side to side. The Petitioner further testified that she has lost strength in her right arm and has difficulty with lifting and performing certain activities of daily living.

The Arbitrator notes that the Petitioner's complaints are corroborated in the medical records of the Petitioner's treating doctors, Dr. Kolb and Dr. Cohen, as well as the records and testimony of the Respondent's examining physician, Dr. Balaram. The Arbitrator further notes that the Petitioner demonstrated her limitations of movement at the time of hearing and that the limitations observed by this Arbitrator were significant and consistent with the nature of the Petitioner's injury and the examination findings, operative reports, and opinions of Dr. Cohen and Dr. Balaram. The Petitioner's complaints as supported by the medical records, evidences a significant disability as indicated by Commission decisions regarded as precedent pursuant to Section 19(e).

The determination of permanent partial disability is not simply a calculation but an evaluation of all 5 factors as stated in the Act. In making this evaluation of permanent partial disability, the Arbitrator has considered all of the appropriate factors and finds that the most significant factor in the instant matter is the Petitioner's credible testimony as to her disability and the corroborating evidence contained in the records of the Petitioner's medical treatment and the examination findings of Dr. Cohen and Dr. Balaram

Based upon the foregoing, and having considered the factors enumerated in Section 8.1(b) of the Act and the totality of the credible evidence adduced at hearing, the Arbitrator finds that as a result of her accidental injuries the Petitioner has sustained a 45% disability to her right arm.

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

Afton Thomas,
Petitioner,

vs. NO: 12 WC 13958

Ruan Transportation,
Respondent.

15IWCC0636

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 14, 2014, is hereby affirmed and adopted.

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

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

15IWCC0636

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $31,300.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 0 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/12/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS, AFTON
Employee/Petitioner

Case# **12WC013958**

15IWCC0636

RUAN TRANSPORTATION
Employer/Respondent

On 10/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2489 LAW OFFICE OF JIM BLACK & ASSOC
TRACY L JONES
303 W STATE ST SUITE 300
ROCKFORD, IL 61101

0075 POWER & CRONIN LTD
WILLIAM P DEWYER
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

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

Afton Thomas
Employee/Petitioner

v.

Ruan Transportation
Employer/Respondent

Case # **12** WC **13958**

Consolidated cases: **N/A**

15IWCC0636

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Geneva**, on **August 21, 2014**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 8, 2012**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$62,603.85**; the average weekly wage was **$1,204.11**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit 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 **$3,512.96** under Section 8(j) of the Act. *See also* AX1 regarding further stipulation.

ORDER

As explained in the Arbitration Decision Addendum, Petitioner established that she sustained a compensable accident on February 17, 2012 and causal connection between her low back condition and injury at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $802.74/week for 14 & 1/7th weeks, commencing July 23, 2012 through October 29, 2012, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from March 8, 2012 through August 21, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of the bills submitted into evidence as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a credit for any 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.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 23.75 weeks, because the injuries sustained caused the 12.5% loss of the left hand, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $695.78/week for 28.5 weeks, because the injuries sustained caused the 15% loss of the right hand, as provided in Section 8(e) of the Act.

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

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

Signature of Arbitrator

October 9, 2014
Date

OCT 14 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Afton Thomas
Employee/Petitioner

v.

Ruan Transportation
Employer/Respondent

Case # **12** WC **13958**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include accident, causal connection, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to temporary total disability benefits from July 23, 2012 through October 29, 2012, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that she was employed by Respondent as a no-touch freight driver for approximately seven years and she remains so employed. In March 2012, her duties were to come to the terminal in DeKalb, "pre-trip" the truck, get paperwork in the office, hook the trailer to the truck and transport the trailer to the Target store. Petitioner testified that she was a dedicated driver for Respondent's client, Target. At the store, Petitioner would do a "double drop and hook." She testified that she would drop the trailer to the side, re-hook another trailer returning to DeKalb, and leave paperwork in a box there.

Generally, Petitioner testified that she went from DeKalb to St. Louis five times per week. She would work at night and be back in the morning. Petitioner testified that she drove 5-5 ½ hours each day. She also testified that she was assigned to different trucks, some internationals and one or two freightliners. Petitioner testified that each truck handled differently, but she used both legs and arms to drive. She testified that her supervisor was Mr. Files.

Once the truck was on the highway Petitioner testified that she would mostly drive with her right hand. Petitioner is right-hand dominant. She explained that if she was holding the steering wheel with both hands, she would usually drive it with her hands gripping the wheel toward the bottom of the wheel and her palms facing upward. Depending on the driving conditions, Petitioner would grip the steering wheel differently and she testified that her wrists were bent. Petitioner acknowledged that the truck she drove had power steering, but testified that the trucks are so big that even with power-steering truck they were still difficult to drive.

Petitioner testified that she lost about 200 pounds before March 8, 2012 which took her a couple of years. She also had high blood pressure and was taking blood pressure medication, as well as an acid reflux pill and cholesterol medication. Petitioner testified that she still occasionally smokes pipe tobacco, but she has not smoked cigarettes in ten years.

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

March 8, 2012

Petitioner testified that while she was on long trips to St. Louis in March 2012, her arms would feel weird. She explained that at approximately the second or third hour of driving she would feel numbness and tingling in her arms.

She then went to see her primary care physician, Dr. Washington, on March 8, 2012. PX1 at 4-8; RX5. Petitioner testified that she told him her symptoms and discussed with him what she did at work. She also testified that Dr. Washington asked her what she did at work.

The medical records reflect Petitioner's weight loss of 211 pounds in the prior year, current weight of 278 pounds, hypertension management through medication, and a 10 year smoking habit of 1 ½ packs per day that she wanted to cease. *Id.* Dr. Washington also noted "bilateral wrist pain off and on for a while.....since 1/1/12 been having worse aching and numbness-wants referral for carpal tunnel[.]" *Id.* With regard to her wrists, Dr. Washington noted that Petitioner's symptoms, including numbness and tingling, swelling, inability to bear weight, and limited range of motion, had been worsening and were at a level of 4/10. *Id.* He diagnosed bilateral carpal tunnel syndrome, right worse than left. *Id.*

Dr. Washington referred Petitioner to a neurosurgeon on April 4, 2012. *Id.* PX1 at 9-11. Petitioner underwent the recommended EMG, which revealed bilateral carpal tunnel syndrome. PX1-PX2. Petitioner returned to Dr. Washington on three more occasions. PX1 at 12-14.

On May 9, 2012, Petitioner reported difficulty holding things and having to stop frequently due to numbness and tingling. *Id.* On examination, Dr. Washington noted numbness, weakness, and pain with range of motion of the wrists. *Id.* He ordered another Medrol Dosepak and indicated that Petitioner may need to stop driving if no relief. *Id.*

On May 30, 2012, Petitioner reported that the Medrol Dosepak had improved her pain. PX1 at 15-17. He diagnosed her with progressive bilateral carpal tunnel syndrome. *Id.*

On June 5, 2012, Petitioner reported continuing symptoms in the wrists and extending up to the bilateral shoulders. PX1 at 18-20. He placed her off work, refilled her medications, and noted the severity of her bilateral carpal tunnel syndrome as reflected in her EMG. *Id.* Petitioner testified that Dr. Washington referred her to Dr. Scott Nyquist. *See also* PX1.

The medical records reflect that Petitioner first saw Dr. Nyquist on June 28, 2012. PX2 at 40-44; RX4. Petitioner testified that she discussed her job duties with him and explained to him how she held the steering wheel at work.

Dr. Nyquist noted that Petitioner was right hand dominant and reported numbness and tingling in both hands for the last several months. *Id.* Petitioner reported that she felt it was related to the repetitive-type tasks she performs at work, which sounded like a manual transmission to him. *Id.* Petitioner had been off work for three weeks. *Id.* Dr. Nyquist reviewed Petitioner's EMG which showed bilateral carpal tunnel syndrome and he recommended bilateral carpal tunnel release surgery. *Id.* He also kept Petitioner off work at that time. *Id.*

Petitioner returned to Dr. Nyquist on July 23, 2012 at which time she decided to proceed with surgery. PX2 at 53-56. He kept her off work. *Id.*

Petitioner underwent a right carpal tunnel release on July 27, 2012. PX2 at 50. She returned to Dr. Nyquist postoperatively on August 10, 2012 reporting improvement in the right wrist and continued symptoms in the left wrist. PX2 at 48-49. Petitioner testified that she underwent physical therapy post-operatively. *See also* PX2. Petitioner then underwent a left carpal tunnel release on August 29, 2012. PX2 at 29.

Dr. Nyquist completed a narrative report dated September 20, 2012. PX3. In his report, Dr. Nyquist reviewed Petitioner's medical treatment and her reports to him about her condition throughout treatment. *Id.* He indicated that Petitioner had bilateral carpal tunnel syndrome that he felt was related to the repetitive type tasks that she performed at work. *Id.*

Section 12 Examination – Dr. Neal

Petitioner submitted to an independent medical evaluation with Dr. Bryan Neal at Respondent's request on September 26, 2012. RX1 (Dep. Exh. 2). Dr. Neal reviewed various treating medical records, Petitioner's job description, examined Petitioner and rendered various opinions. *Id.*

At the time of her examination, Petitioner reported that she worked for Respondent as a truck driver in a manual transmission truck. *Id.* She also reported that she believed that her carpal tunnel syndrome was related to her work. *Id.*

After taking a history, performing a physical examination, and reviewing various records, Dr. Neal diagnosed Petitioner with bilateral carpal tunnel syndrome. *Id.* He noted that her EMG supported the diagnosis. *Id.* Dr. Neal also opined that there was no causal connection between Petitioner's bilateral carpal tunnel syndrome and her work duties as a truck driver. *Id.* In so concluding, Dr. Neal indicated that Petitioner had no symptoms during her seven years as a truck driver and there was no significant data supporting truck driving with a manual gear shift and power steering, and the onset of carpal tunnel syndrome. *Id.*

Dr. Neal noted that Petitioner had two universally accepted risk factors for carpal tunnel syndrome, obesity and her female gender. *Id.* He opined that Petitioner's work duties did not aggravate her pre-disposition for carpal tunnel syndrome based on these factors and that if Petitioner's subjective complaints continued while she was not working this would further support his opinion that her condition was not causally related to her duties at work. *Id.* He also opined that Petitioner's medical treatment, while necessary, was not causally related to any injury caused by her duties at work. *Id.*

Dr. Neal was called as a witness by Respondent and he gave testimony at an evidence deposition on April 18, 2014. RX1. Dr. Neal is a board-certified orthopedic surgeon who completed a one-year hand and upper extremity fellowship and sub-specializes in hand surgery. RX1 at 5, 7-8.

He testified about his independent medical evaluation of Petitioner, his review of records, and subsequent opinions. RX1 at 8-14. At the time of his deposition, Dr. Neal maintained his opinion that Petitioner's condition was not causally related to her work duties. RX1 at 14-15. He explained that there are some underlying conditions that can cause carpal tunnel syndrome including obesity and the female gender. RX1 at 15-16.

Dr. Neal further opined that Petitioner's job duties as a truck driver neither caused nor aggravated Petitioner's bilateral carpal tunnel syndrome condition. RX1 at 16. He explained that he was confident that the "underlying

cause and probably the sole cause of her carpal tunnel syndrome was a combination of two factors[;]" Petitioner's morbid obesity and dramatic weight loss in one year. RX1 at 17-18, 22-23. He further testified that it had never been shown that the occupation of driving was causally related to carpal tunnel syndrome or that it permanently worsened a pre-existing condition. RX1 at 18-19.

Dr. Neal clarified that, while there was gripping involved with a steering wheel, he did not consider driving to be a repetitive task or that Petitioner's driving required the type of forceful gripping necessary to cause changes in intracarpal pressures or extreme flexion or extension. *Id.* Thus, Dr. Neal opined that Petitioner's need for medical treatment for the carpal tunnel syndrome was not causally related to her duties at work. RX1 at 19-20.

On cross examination, Dr. Neal agreed that at the time of his examination of Petitioner she was not obese. RX1 at 21. He acknowledged that there was no evidence in the medical records of Petitioner's complaints of symptoms of carpal tunnel syndrome before January 2012. RX1 at 23-24. He also agreed that extreme flexion and extension elevated pressure in the carpal tunnel which could lead to median nerve dysfunction manifesting in carpal tunnel syndrome. RX1 at 24-25. Dr. Neal also agreed that forceful gripping or grasping, repetitively, was associated with increased carpal tunnel pressure and that forceful gripping over a significant period of time could lead to and cause carpal tunnel syndrome. RX1 at 25. He further agreed that there needed to be both an element of repetition and forcefulness to cause carpal tunnel syndrome. RX1 at 27.

With regard to the details of Petitioner's driving, Dr. Neal testified that he did not know how Petitioner positioned her hands and wrists while driving. RX1 at 28. He also acknowledged that he did not see Petitioner's EMG studies or carpal tunnel surgical reports. RX1 at 29-30.

Continued Medical Treatment

She continued in the care of Dr. Nyquist through November 29, 2012. PX2 at 36-38; RX3. On that date, he released her from care at maximum medical improvement. *Id.* Petitioner did follow up once more on January 9, 2013 reporting some continued complaints, although there was improvement in her symptoms. PX2 at 6.

Petitioner testified that she was off work from July 23, 2012 through November 29, 2012. She testified that her condition improved slightly. She also testified that she understands that she has unpaid medical bills remaining and she testified that she made some out of pocket payments throughout her medical treatment.

Dr. Nyquist – Deposition Testimony

On April 10, 2014, Petitioner called Dr. Nyquist as a witness and he gave testimony at an evidence deposition. PX4. Dr. Nyquist is a board-certified orthopedic surgeon focusing on hips, knees and shoulders, but that he also takes care of carpal tunnel syndrome in patients. PX4 at 3. He explained later that he has performed approximately 500-600 carpal tunnel release surgeries. PX4 at 7.

Dr. Nyquist testified that Petitioner reported to him that her work for Respondent was repetitive in nature. PX4 at 6-7. She reported to him that she was required to hold "onto a shaky steering wheel" and he felt that it was the most likely factor in the causation of her carpal tunnel syndrome. *Id.* He explained that when people perform repetitive tasks involving flexion and extension of the fingers and wrists and grasping of the hands, these activities can cause a tendinitis and tightness in the carpal tunnel. PX4 at 7-8. He indicated that there is usually associated numbness and tingling. *Id.*

Dr. Nyquist also reviewed Petitioner's job description, which he found to be more detailed than what Petitioner reported to him about her job duties, but which was nonetheless consistent with what she reported to him. PX4 at 8-9; *see also* PX5; RX2.

Dr. Nyquist opined that Petitioner's bilateral carpal tunnel syndrome condition was caused or aggravated by her work activities. PX4 at 9. He explained that carpal tunnel syndrome is multi-factorial, but he was not aware of other significant causes to her condition or need for surgery. *Id.*

On cross examination, Dr. Nyquist acknowledged that carpal tunnel syndrome is multi-factorial and sometimes idiopathic in nature. PX4 at 14. He also testified that he was not aware that Petitioner was a smoker and she did not report that to him, but that it would not likely change his opinion. PX4 at 15, 22-23. He did not recall Petitioner being particularly obese. PX4 at 16-17. He also testified that he was not aware of high blood pressure or hypotension being causative or aggravating factors in carpal tunnel syndrome. PX4 at 23, 25. Dr. Nyquist testified that carpal tunnel syndrome is highly associated in pregnant women and diabetics with neuropathy. PX4 at 23-25. In Petitioner's case, Dr. Nyquist noted that Petitioner's EMG did not show neuropathy. PX4 at 28.

Dr. Nyquist further testified that he did not know the size of the steering wheel that Petitioner used while working for Respondent, or how forcefully she gripped the wheel, how many miles she drove, or the condition of her truck. PX4 at 19-20. He opined that Petitioner's report that her job required repetitive operations or tasks created a causal relationship between her driving and carpal tunnel condition. PX4 at 20-21.

Additional Information

Petitioner testified that she continues to work for Respondent from their Cedar Falls facility and lives in Rockford. Petitioner testified that she drives from her home to DeKalb to pick up the tractor and then drives to Cedar Falls, which takes about 3 ½ - 4 hours. Petitioner testified that she works her regular driver duties and has no medical restrictions.

Regarding her current condition of ill-being, Petitioner testified that her hands are not 100% recovered, but they are slightly better. She does not experience numbness and tingling so much, but she also testified that it is hard for her grip small things.

Ryan Files

Respondent called Ryan Files ("Mr. Files') as a witness. He testified that he is employed by Respondent as a terminal manager at the DeKalb facility. Mr. Files testified that Petitioner was delivering trailers to customers' stores and that she would drive the tractor at the door, hooking and unhooking the trailer, and bringing another trailer back to the DeKalb facility. He testified that Petitioner did longer routes for Respondent.

Mr. Files testified about Respondent's Exhibit 2, which is a job description for "no touch freight." He explained that drivers are not to touch the freight for liability purposes. Whether this job is easier or harder depends on the definition of that.

Mr. Files testified that Petitioner reported problems to him sometime in March 2012 and he completed an incident report. Petitioner reported that her wrist was bothering her and that she was going to see a doctor. Mr. Files testified that Petitioner reported to him that she believed that it could be because of her driving.

Mr. Files testified that Respondent has different tractors of different ages and that the steering wheels in the tractors are different, larger. He testified that the tractors have power steering, but that a truck driver would have to change positions holding the steering wheel while driving.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

In repetitive-injury cases, the facts must be closely examined to ensure a fair result for both the faithful employee and the employer. *Durand v. Industrial Comm'n*, 224 Ill. 2d 53, 71 (2006). Compensation is allowable where an injury is not sudden, but gradual so long as it is linked to the claimant's work. *Durand*, 224 Ill. 2d at 66. The Court went on to highlight its *Peoria County* decision stating that "[t]o deny an employee benefits for a work-related injury that is not the result of a sudden mishap *** penalizes an employee who faithfully performs job duties despite bodily discomfort and damage." *Durand*, 224 Ill. 2d at 66 (*citing Peoria County Belwood Nursing Home v. Industrial Comm'n*, 115 Ill. 2d 524, 529-30 (1987)).

"Recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Sisbro*, 207 Ill. 2d at 204-206; *Caterpillar Tractor Co.*, 92 Ill. 2d at 36-37.

In this case, Petitioner testified about and demonstrated the method in which she drove the manual transmission, power-steering tractor for Respondent up through January of 2012 when she started developing symptoms in her hands. Petitioner admitted that she was over 200 pounds heavier in the year or two before her alleged accident at work and that she was previously a heavy smoker, but she had quit. The medical records generally corroborate Petitioner's testimony about her medical history and there is no dispute between the parties about Petitioner's pre-existing morbid obesity, smoking history, or hypertention and other co-morbitities.

The parties' dispute essentially centers on whether Petitioner engaged in the generally accepted forceful gripping or grasping associated with carpal tunnel syndrome such that Petitioner's gripping or grasping of the steering wheel of the tractor with which Respondent provided her contributed in any part to her carpal tunnel syndrome. In consideration of the record as a whole, the Arbitrator finds that Petitioner's job duties as a truck driver as described required her to forcefully grasp a steering wheel sufficient to contribute to her bilateral carpal tunnel syndrome.

In so finding, the Arbitrator notes the opinions of Petitioner's treating physician, Dr. Nyquist, and Respondent's Section 12 examiner, Dr. Neal. Both physicians are board-certified orthopedic surgeons. Dr. Neal appears to specialize in hand surgery. Dr. Nyquist has performed hundreds of carpal tunnel release surgeries and

physically examined Petitioner over several months. Both physicians reviewed Petitioner's job description and obtained a history from her about her driving duties.

In consideration of all of the medical evidence, the Arbitrator does not find the opinions of Dr. Neal to be persuasive in this case that the sole factors causing Petitioner's bilateral carpal tunnel syndrome were occupational in nature. To the contrary, the evidence from Petitioner and as reflected in her treating medical records from Dr. Nyquist and Dr. Washington establishes that her symptoms developed while engaged in her driving duties.

Petitioner plausibly explained that, while her tractor had power-steering, she still was required to forcefully grip the wheel over hours to maneuver the truck and she demonstrated the flexed position in which she forcefully gripped the wheel while driving for a majority of the time that she did so. She also credibly described the way in which she operated her truck and the difficulties in maneuvering the truck in different weather, which is corroborated by her supervisor, Mr. Files. While Petitioner acknowledged that she still had symptoms while she was not driving and placed off work initially by Dr. Washington, she described her symptoms to be less during that period than during her work for Respondent.

Notwithstanding, Dr. Washington and Dr. Nyquist's records reflect Petitioner's reported onset of symptomatology in January of 2012, which she clearly related to her duties at work. There is no real dispute between the parties about Petitioner's co-morbities. Precedent however does not require that a claimant prove that her occupation is the only factor causing her condition. While Dr. Neal reasonably testified that there were non-occupational contributing factors to Petitioner's carpal tunnel syndrome, including her morbid obesity and associated dramatic weight loss as well as her female gender, "recovery for an accidental injury will not be denied as long as it can be shown that the employment was also a causative factor." *Sisbro*, 207 Ill. 2d at 204-206.

Petitioner, who was young at the time of her alleged accident at work (30 years of age), plausibly testified about a mechanism of injury to both hands (right worse than left) in which she developed clinically correlated carpal tunnel syndrome as a result of her activities operating a truck for Respondent. Petitioner had been working for Respondent as truck driver in a full-time capacity for approximately seven years without any need for medical treatment to either hand or any complaints of symptoms in either hand despite hypertension, obesity, or years of smoking. The symptoms that Petitioner testified she experienced when she saw Dr. Washington were enough to prompt her to seek medical attention for the first time in March 2012, which she testified resulted from having to continuously and forcefully grip a steering wheel over hours every day while driving for Respondent.

In light of the record as a whole, the Arbitrator finds the testimony of Petitioner to be credible and the opinions of Dr. Nyquist to be more persuasive than those of Dr. Neal. Based on all of the foregoing, the Arbitrator finds that Petitioner did sustain an accident that arose out of and in the course of her employment with Respondent as claimed on March 8, 2012.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

As explained in the accident analysis above, the Arbitrator finds that Petitioner sustained a compensable repetitive trauma injury to her bilateral hands at work as claimed. No evidence was presented regarding any intervening injury that would break the chain of causal connection through the date that Petitioner was released

to full duty work by Dr. Nyquist or thereafter. Based on all of the foregoing, the Arbitrator finds that Petitioner has established a causal connection between her claimed current condition of ill being and her accident at work.

In support of the Arbitrator's decision relating to 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 the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (*citing University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)).

As explained in the accident and causation analyses above, the Arbitrator finds that Petitioner sustained a compensable injury at work and that her bilateral hand condition of ill being is causally related to that accident. Moreover, Respondent's Section 12 examiner, Dr. Neal, noted that the medical treatment rendered to Petitioner through the date of his examination was reasonable and necessary, regardless of his opinions regarding causation.

Based on all of the foregoing, the Arbitrator awards the reasonable and necessary medical bills incurred by Petitioner and submitted into evidence to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (K), Petitioner's entitlement to temporary total disability benefits, the Arbitrator finds the following:

"The period of temporary total disability encompasses the time from which the injury incapacitates the claimant until such time as the claimant has recovered as much as the character of the injury will permit, i.e., until the condition has stabilized." *Gallentine v. Industrial Comm'n*, 201 Ill. App. 3d 880, 886 (2nd Dist. 1990). The dispositive test is whether the claimant's condition has stabilized, i.e., reached MMI. *Sunny Hill of Will County v. Ill. Workers' Comp. Comm'n*, 2014 IL App (3d) 130028WC at *28 (opinion filed June 26, 2014); *Mechanical Devices v. Industrial Comm'n*, 344 Ill. App. 3d 752, 760 (4th Dist. 2003). To show entitlement to temporary total disability benefits, a claimant must prove not only that she did not work, *but also that she was unable to work*. *Gallentine*, 201 Ill. App. 3d at 887 (*emphasis* added); *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

In this case, the record reflects that Petitioner was undergoing active medical treatment and placed off work through by her treating physicians as related to her bilateral carpal tunnel syndrome condition. Thus, in light of the accident and causal connection analyses explained above and the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits for the period claimed from July 23, 2012 through October 29, 2012.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Section 8.1b of the Illinois Workers' Compensation Act ("Act") addresses the factors that must be considered in determining the extent of permanent partial disability for accidents occurring on or after September 1, 2011. 820 ILCS 305/8.1b (LEXIS 2011). Specifically, Section 8.1b states:

For accidental injuries that occur on or after September 1, 2011, permanent partial disability shall be established using the following criteria:

(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. *Id.*

Considering these factors in light of the evidence submitted at trial, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

First, no 8.1b subsection (a) report delineating Petitioner's level of impairment was submitted into evidence by either party. Thus, the Arbitrator considers the parties to have waived their right to do so and assigns no weight to this factor.

Second, the evidence established that Petitioner was a truck driver. The Arbitrator finds Petitioner's and Mr. Files' testimony regarding her duties at work on the date of accident to be credible and further notes the documentary evidence of Petitioner's job description. As this evidence is uncontroverted, the Arbitrator assigns it significant weight.

Third, the parties stipulated that Petitioner was 30 years old on the date of accident. There is no evidence that Petitioner had any prior complaints in either hand previously. This evidence is uncontroverted and, thus, the Arbitrator assigns it significant weight.

Fourth, while there is evidence reflecting Petitioner's physical capabilities (i.e., Petitioner's own testimony, the testimony of Mr. Files, Dr. Washington and Dr. Nyquist's medical records releasing Petitioner to full duty work, etc.) no evidence was introduced regarding Petitioner's future earning capacity as a result. Thus, no weight is assigned to this factor as there is no evidence of any impact on Petitioner's future earning capacity as a result of her injury.

Fifth, the treating medical records reflect that Petitioner underwent medical treatment that included two separate carpal tunnel release surgeries on the right and left sides. Petitioner continued with post-operative physical therapy and followed up with her orthopaedic surgeon, Dr. Nyquist, for several months. Petitioner credibly testified that after hers release back to full duty work she is able to perform her duties, but has continued difficulty grasping or holding items. In view of all of the foregoing, the Arbitrator finds that there is credible evidence of ongoing disability as reflected in the treating medical records corroborating Petitioner's testimony of continuing symptomatology in both hands. Thus, the Arbitrator assigns it significant weight.

Based on all of the foregoing, and in consideration of the factors enumerated in Section 8.1b, which does not simply require a calculation, but rather a measured evaluation of all five factors of which no single factor is conclusive on the issue of permanency, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 12.5% loss of use of the non-dominant left hand and that she sustained permanent partial disability to the extent of 15% loss of use of the dominant right hand pursuant to Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Enrique Castellanos,
Petitioner,

vs. No: 12 WC 21823

15IWCC0637

Allen Brothers.,
Respondent.

DECISION AND OPINION ON REVIEW

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

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

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

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

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.

15IWCC0637

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 0 2015

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

o-08/12/15
jdl/wj
68

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

CASTELLANOS, ENRIQUE
Employee/Petitioner

Case# **12WC021823**

ALLEN BROTHERS INC
Employer/Respondent

15IWCC0637

On 1/9/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICES JAMES P McHARGUE
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2837 LAW OFFICES JOSEPH MARCINIAK
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CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Enrique Castellanos,
Employee/Petitioner
v.
Allen Brothers, Inc.
Employer/Respondent

Case # **12** WC **21823**

15IWCC0637

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **October 29, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **January 23, 2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**29,733.60**; the average weekly wage was $**571.80**.

On the date of accident, Petitioner was **30** years of age, *married* 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 $**3,422.16** for TTD, $**0** for TPD, $**0** for maintenance, and $**1,715.40** for other benefits, for a total credit of $**5,137.16.**

Respondent is entitled to a credit of $**4,107.45** under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**381.20**/week for **21 3/7**^{ths} weeks, commencing **January 24, 2012** through **June 21, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **January 24, 2012** through **June 21, 2012**.

Respondent shall be given a credit of $**5,137.16** for benefits that have been paid.

Respondent shall pay for medical services incurred from January 23, 2012 through June 21, 2012 only, as provided in Section 8(a) of the Act. Respondent is to pay any unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule or the negotiated rate and shall provide documentation with regard to said fee schedule or negotiated rate calculations to Petitioner. Respondent is to reimburse Petitioner directly for any out of pocket medical payments.

Respondent shall be given a credit of $**4,107.45** 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 be given a credit for all medical benefits paid under Section 8(a) 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.

Milton Black

Signature of Arbitrator

January 8, 2015
Date

JAN 9 - 2015

FACTS

Petitioner testified that on January 23, 2012 he was lifting a box and felt pain in his lower back.

Petitioner testified that the following morning he sought treatment from at Marque Medicos. Petitioner was diagnosed with lower back pain (PX 7). Thereafter, he was seen by Dr. Engel of Medicos Pain & Surgical Specialists for pain management. He was given medication and directed to attend physical therapy (PX 6). He was to continue physical therapy and return to work with restrictions. Petitioner was diagnosed with lower back pain syndrome and directed to continue with medication and physical therapy.

An MRI of the lower back revealed a disc bulge at L5-S I with central annular tearing (PX 6).

Petitioner returned to Dr. Engel and epidural steroid injections were recommended and given (PX 6, PX 5). He was eventually referred to neurosurgeon Dr. Robert Erikson and directed to continue to work light duty (PX 6).

Petitioner was seen by Dr. Erickson of The American Center for Spine & Neurosurgery. The doctor noted that a fusion surgery could be an option but that conservative care was recommended (PX 2).

Petitioner was seen for an independent medical examination by Dr. Alexander Ghanayem of Loyola University Medical Center. Physical examination revealed petitioner had a normal posture and gait. The lumbar spine showed minimal discomfort at the base and good range of motion. Neurologically petitioner was normal. Tension signs were negative for radicular pain. Review of the MRI revealed mild L5-S1 disc

degeneration. Dr. Ghanayem opined that petitioner aggravated his lumbar disc degeneration and sustained a back sprain from his work injury. He noted that petitioner's physical examination was benign with normal neurologic findings and excellent lumbar range of motion. Dr. Ghanayem opined petitioner could return to work full duty and had reached MMI (RX 1).

Petitioner came under the care of Dr. Ossama Abdellatif of Pro Clinics and Chicagoland Advanced Pain and Headache Clinics, LTD. Petitioner was diagnosed with lumbar radiculopathy and lumbar facet syndrome. An EMG was recommended, and petitioner was to continue physical therapy (PX 10). Petitioner underwent a trigger point and epidural steroid injection and lumbar facet block by Dr. Abdellatif at Fullerton Surgery Center (PX 4). Petitioner underwent a second and third injection and lumbar facet block by Dr. Abdellatif (PX 4). Petitioner was also advised to seek a surgical consult (PX 10).

An August 6, 2012 chart note by Dr. Engel states that he reviewed Dr. Ghanayem's report and that he agreed that petitioner had reached maximum medical improvement as of June 21, 2012 (PX 6).

Petitioner returned to Dr. Abdellatif complaining of lower back pain with radiation. A discogram and CT scan were recommended (PX 10).

Petitioner underwent a discogram at Fullerton Surgery Center which revealed concordant pain at L4-5 and L5-S1. A CT scan of the lumbar spine demonstrated abnormal discs at L2-3, L3-4, L4-5 and L5-S1 (PX 4). Petitioner followed up with Dr. Abdellatif, and a disc decompression was recommended (PX 10).

Petitioner underwent a discectomy at L4-5 and L5-S1 performed by Dr. Abdellatif on January 14, 2013 at Fullerton Surgery Center (PX 4). Thereafter, petitioner followed up with Dr. Abdellatif (PX 10).

Petitioner was seen for an initial consultation by Dr. Sean Salehi on February 26, 2013. Petitioner was working light duty. Petitioner was diagnosed with lumbar degenerative disc disease with right leg symptoms. An updated lumbar MRI was recommended. The doctor also wanted to review the previous MRI. The doctor indicated he did not believe petitioner was a surgical candidate due to his young age unless the pain was intolerable. He was directed to continue working light duty (PX 1).

Petitioner returned to Dr. Salehi and complained of constant pain in the lower back with pain down the right leg to the foot. He was working light duty. Dr. Salehi and petitioner discussed either an FCE or a single-level fusion at L5-S1 (PX 1).

Petitioner followed-up with Dr. Abdellatif for constant lower back pain with radiation to the bilateral extremities. The doctor commented that petitioner had reached maximum medical improvement. Petitioner was directed to follow-up as needed but to follow-up with a surgical consultation (PX 10).

Petitioner was seen for another examination by Dr. Ghanayem. Petitioner reported that he had pain at the base of his lumbar spine that radiated up his entire spine to the base of his neck with bilateral leg symptoms. The doctor opined that petitioner exhibited multiple nonorganic physical findings with symptom magnification. Dr. Ghanayem continued to opine that petitioner had a lower back sprain and aggravation from his underlying disc degeneration of his lumbar spine. It was an issue that should have been treated conservatively. He maintained the opinion that petitioner had reached maximum medical improvement and required no further care, required no restrictions, and could return to work full duty. Petitioner did not have a disc herniation and was not a surgical candidate (RX 3).

Petitioner was seen by Dr. Salehi on March 4, 2014. The doctor stated that since petitioner was seen one year prior, his lower back pain was worse and he had pain to the right foot. He had been working with restrictions. Petitioner was diagnosed with a lumbar herniated disc at L5-S1 and recommended an updated MRI (PX 1). Petitioner was seen on May 5, 2014 and June 14, 2014by Dr. Salehi. Petitioner was diagnosed with a lumbar degenerative disc disease and a herniated disc. Surgery was offered (PX 1).

CAUSATION

The Arbitrator finds that Dr. Ghanayem's opinions are persuasive. Dr. Ghanayem noted that petitioner's physical examination was benign with normal neurologic findings and excellent lumbar range of motion. Dr. Ghanayem reviewed the MRI and noted only mild disc degeneration at L5-S1. After examination and reviewing all of the records and films in their totality and comparing the findings to his own physical findings, Dr. Ghanayem felt that petitioner aggravated his lumbar disc degeneration and sustained a

back sprain from his work injury. He opined that petitioner could return to work full duty and had reached maximum medical improvement (RX 1).

Petitioner continued to treat conservatively with injections and physical therapy. Despite the treatment being rendered, petitioner continued to complain of pain. However, his pain complaints were varied. Throughout the medical records, petitioner's complaints regarding his radiculopathy shifted upon when and to whom he reported them to.

Dr. Ghanayem notes after his second examination that petitioner exhibited multiple nonorganic physical findings consistent with symptom magnification (RX 3).

Petitioner's treating physician, Dr. Engel, stated in his office note that he agreed with Dr. Ghanayem's opinions and likewise felt that petitioner had in fact reached maximum medical improvement as of June 21, 2012 (PX 6).

The Arbitrator is persuaded by Dr. Ghanayem's opinions that petitioner sustained a lumbar sprain. The Arbitrator finds that Dr. Ghanayem's opinions on causation are supported by the medical records. The Arbitrator finds that petitioner does not require any further medical treatment related to his accident and that petitioner has reached maximum medical improvement.

MEDICAL

Based on the causation analysis, the Arbitrator finds that all medical treatment after the maximum medical improvement date of June 21, 2012 is denied.

Based on the causation analysis, the Arbitrator further finds that petitioner is not entitled to the claimed prospective medical treatment.

TEMPORARY TOTAL DISABILITY

The parties stipulated that temporary total disability benefits are payable from January 23, 2012 through March 19, 2012. Those benefits are granted.

Based on the causation analysis, temporary total disability benefits are payable through the June 21, 2012 maximum medical improvement date.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carlos Gutierrez Mendoza,
Petitioner,

vs. NO: 10 WC 32404

Gibsons/Quartino,
Respondent.

15IWCC0638

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 8, 2014, is hereby affirmed and adopted.

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

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

15IWCC0638

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $3,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 0 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/12/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MENDOZA, CARLOS GUTIERREZ
Employee/Petitioner

Case# 10WC032404

15IWCC0638

GIBSONS/QUARTINO
Employer/Respondent

On 9/8/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0243 JAMES ELLIS GUMBINER & ASSOC
CHRISTOPHER TOMCZYK
180 N MICHIGAN AVE SUITE 2100
CHICAGO, IL 60601

1454 THOMAS & ASSOCIATES
MICHAEL PILLER
500 W MADISON ST SUITE 2900
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

CARLOS MENDOZA GUTIERREZ
Employee/Petitioner

v.

GIBSONS/QUARTINO
Employer/Respondent

Case # **10** WC **32404**

Consolidated cases: **none**

15IWCC0638

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on July 24, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **8/14/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$16,567.20**; the average weekly wage was $**318.60**.

On the date of accident, Petitioner was **29** 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 $**1,798.07** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**1,798.07**.

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 $220.00/week for 5-1/7 weeks, commencing August 23, 2010, through September 27, 2010, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $1,798.07 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services all such services up to and including September 27, 2010 as provided in Section 8(a) of the Act, because Petitioner's condition of ill-being and need for medical services after September 27, 2010, are not causally related to the accident of August 14, 2010.

Respondent shall pay Petitioner permanent partial disability benefits of $220.00/week for 12.843 weeks, because the injuries sustained caused the 1% loss of use of man as a whole, (5 weeks), as provided in Section 8(d)2 of the Act; and 5% loss of use of the right arm less a credit of 1.9% right arm for prior settled claim number 10 WC 32406 (12.65 weeks less credit of 4.807 weeks), as provided in Section 8(e) of the Act.

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

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

FINDINGS OF FACT

Carlos Mendoza Gutierrez ("Petitioner") testified that he was employed as a dishwasher, for Gibsons/Quartino ("Respondent"), in August 2010. On August 14, 2010, Petitioner testified that he sustained injury to his right arm and neck. While inside a cooler, a stack of boxes or containers of oil fell against him. He testified that they struck him on his right arm and knocked him down. He did not testify when he began to feel pain, or when it may have started. He continued working at his job thereafter, and did not seek medical attention for four (4) days, stating that he was waiting for his employer to send him to a doctor. He gave no testimony as to when he first asked his employer to see a doctor. The Concentra report, dated August 18, 2014, noted that the patient did not report his injury to the company until "1 day ago," per company report. Petitioner did not explain why he felt he needed his employer's referral before seeking medical attention. RX1.

He initially presented to Dr. Scott Cole, MD, at Concentra, on August 18 2014. He testified that he told the doctor what part of his body was injured, though he did not state which parts, in his arbitration testimony. Upon cross-examination, Petitioner agreed he told the doctor he "hurt his right arm." He testified that he was examined, given medication, and released to return to his job, with restrictions.

Concentra's records show that Petitioner complained only about his right arm. The doctor quoted Petitioner as saying, "While trying to keep some boxes from falling, I hurt my right arm." The report noted Petitioner's prior stab injury to his right forearm one (1) year prior, in 2009, in which he had similar symptoms of numbness and tingling. The doctor noted the petitioner requested an MRI, and that his pain was "moderate and ill-defined," and located on the right arm. Petitioner denied weakness, stiffness, limited movement and neck pain. An interpreter was present throughout the examination.

Dr. Cole performed an examination of Petitioner, specifically noting, "No cervical spine tenderness; normal range of motion." Further notes record a normal right shoulder, elbow, forearm, wrist and hand. There is no mention of Petitioner falling down, or sustaining injury to his neck or low back. Dr. Cole's assessment was, "forearm contusion." He prescribed ibuprofen 200 mgs, and released Petitioner to "regular activity". This is contrary to Petitioner's testimony at arbitration that he was released by the doctor at Concentra with restrictions, which his employer "did not respect." RX1, pgs. 1-2.

Petitioner next saw Dr. Malas, a chiropractor, on August 23, 2010. He continued to work at his regular job during the interim. Dr. Malas' records are the first to note Petitioner's complaint that his neck was injured. Dr. Malas commenced treatment for Petitioner, which lasted until his discharge from his care in January 2011. Dr. Malas then gave Petitioner a release to return to work in a full duty capacity. PX1.

On September 27, 2010, Petitioner presented to Dr. Michael Kornblatt, by request of Respondent. Petitioner initially testified that the examination lasted thirty (30) minutes; Petitioner then testified that Dr. Kornblatt conducted no physical examination of him at all; that he only took x-rays and never returned. Petitioner testified that Dr. Kornblatt did not speak Spanish or have an interpreter, but admitted on cross-examination that he brought with a friend to act as an interpreter at that examination.

Dr. Kornblatt's report, dated September 27, 2010, states that Petitioner's history was obtained through an interpreter. The history given was that stacked buckets of oil fell, striking him in the right forearm, causing him to twist his neck. No history or complaint of falling down or low back injury was documented. Dr. Kornblatt noted Petitioner's right forearm pain "has almost completely dissipated."

At the time of Dr. Kornblatt's examination, Petitioner complained of neck pain radiating up and down the neck. Contrary to Petitioner's testimony that this doctor performed no examination of him at all, Dr. Kornblatt's records show that he did perform a physical examination; the results of which he documented in his report. That examination included inspection of the cervical spine, which was noted to have a full range of motion in all directions. Dr. Kornblatt also reviewed the film of the August 26, 2010 MRI, from Lincoln Imaging Center. The radiologist's report noted, "C4-5 small right, central protrusion ... without spinal cord compromise," and, C5-6 disk level ... disk bulging identified with no focal herniations." Dr. Kornblatt, upon his review of the MRI film, disagreed with the radiologist's interpretation of the MRI. In Dr. Kornblatt's opinion, the film was "a normal MRI scan of the cervical spine without evidence of herniated disk, spinal stenosis, nerve root or spinal cord impingement, or bony pathologic changes. RX4 pgs. 2-4.

Dr. Kornblatt concluded that Petitioner presented without objective findings to justify his ongoing subjective complaints. He opined that the only conditions causally related to the work accident were a cervical strain and right forearm contusion. In his opinion, neither of these conditions required any time off work nor treatment, other than the three-week course of therapy, which Petitioner had undergone and completed. Finally, Dr. Kornblatt opined that, as of September 27, 2010, Petitioner was at maximum medical improvement ("MMI") and was able to return to his regular job. RX4, pgs.4-5.

In November 2011, Petitioner resumed treatment with doctors at Pro Clinics, where he had been referred by Dr. Malas, in September 2010. Petitioner gave no testimony of what prompted him to return for treatment after being at MMI for over nine (9) months. Petitioner continued to seek and receive treatment and was eventually released by Dr. Malas in January 2011. Petitioner did not testify as to any lost time after that date.

Though he denied having any treatment after receiving a full duty release from Dr. Malas in January 2011, the petitioner treated with Dr. Abdellatif, until November 1, 2011. Petitioner offered into

evidence copies of October 19, 2011 MRI scans of his cervical spine, right and left shoulders, lumbar spine and thoracic spine.

The Pro Clinics consultation report, dated November 1, 2011, noted that Petitioner sought treatment for headaches and low back pain radiating to his right leg. In addition to treatment received after September 27, 2010 for his neck, Petitioner received considerable treatment for lumbar radiculopathy and lumbar disc syndrome. Petitioner offered into evidence records and bills of his treatment, which include diagnostic x-rays, scans, MRIs, trigger injections, and therapy through January 2012. From October 19, 2011 and January 2012, Petitioner did not miss any time from work and is not seeking temporary total disability benefits, for this period. At the time of the arbitration hearing, Petitioner testified he was working at a new job. PX2-7.

CONCLUSIONS OF LAW

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956). It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances [emphasis added] support the decision. See generally, *Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), see also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978).

Following his work injury, Petitioner did not seek medical treatment for four (4) days, and took no time off from work, other than the intervening weekend. His employer's first report of injury, dated August 25, 2010, notes the subject injury to be a reinjury to the right arm only. When Petitioner first sought treatment at Concentra, on August 18, 2010, his only complaint was pain to his right arm, with no mention of pain or problems with his neck, left arm or shoulder, or low back. Dr. Cole, who conducted an examination of Petitioner's cervical spine, reported him as normal, released Petitioner to return to work at his regular duties, on that date. Contrary to this report, Petitioner testified that the Concentra doctor gave him restrictions, which his employer did not respect. The Arbitrator finds the Concentra records, showing that Petitioner was released to full work activities with no restrictions on August 18, 2010, to be more credible than Petitioner's testimony that he was given work restrictions by that clinic.

Dr. Kornblatt, the board certified orthopedic surgeon who performed the Section 12 examination of Petitioner, personally reviewed the cervical MRI films taken on August 26, 2010, and found them to be normal and without evidence of herniated disks, stenosis, nerve root or spinal cord impingement or bony pathologic changes. He recorded no complaints by Petitioner of low back pain. He opined that three (3) weeks of treatment was sufficient for Petitioner to recover from his work-related injuries, i.e. a minor strain of the cervical spine, "by history," and a right forearm contusion.

The Arbitrator finds Drs. Cole and Kornblatt to be credible witnesses and adopts their findings, reports and opinions. No fall or cervical injury was documented by any doctors until Petitioner saw Dr. Malas, on August 23, 2014. Lumbar complaints were not reported until much later. Both Dr. Kornblatt and Petitioner concur that Petitioner had a translator available at the Section 12 examination, whom Petitioner testified he brought with him. The Arbitrator finds that communication between the Petitioner and Dr. Kornblatt was therefore not an issue.

Taking all of the evidence as a whole, the Arbitrator concludes that Petitioner sustained a minor strain of his cervical spine, and a right forearm contusion, because of his August 14, 2010 work injury, both of which had resolved by the date of Dr. Kornblatt's September 27, 2010 examination.

Therefore, the Arbitrator finds that Petitioner has not met his burden of proving that any condition of ill-being after September 27, 2010, was causally related to Petitioner's employment by Respondent.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all reasonable and necessary medical services?

When Petitioner first received treatment following his accident, he complained of moderate and ill-defined right arm pain, similar to the pain he had following his 2009 right arm stab/laceration injury. He stated his current accident caused the symptoms to return. He specifically denied weakness, stiffness, limited movement and neck pain. Examination of his neck revealed no cervical spine tenderness and he had a normal range of motion. Dr. Cole reported a normal examination of Petitioner's right shoulder, elbow, wrist and hand. Petitioner had no complaints of headaches, neck pain, shoulder, arm or low back pain. Dr. Cole's diagnosis and assessment was "Forearm contusion, right."

The Petitioner admitted there was an approximately 10-month gap in medical treatment, i.e. from when he was released at MMI at the end of January 2011 until November 1, 2011. He provided no testimony why he returned for further treatment. Medical records during this period indicate that the treatment received included treatment for complaints not previously made at the time of the subject accident.

Petitioner offered into evidence MRI reports from scans taken in October 2011, of body parts not initially injured or hurt, per Petitioner's testimony. Petitioner received considerable treatment to and diagnostics for his left arm, back and legs; body parts not initially reported as injured on August 14, 2010.

The right arm complaints documented in Pro Clinics' records, were similar to those following his unrelated 2009 accident. Petitioner did not prove, by a preponderance of the evidence, that any of the treatment received to his right arm after January 2011, was causally related to his August 14, 2010 accident, as opposed to his 2009 accident; the latter of which was significant enough to require weeks of treatment and therapy in 2009.

The Arbitrator finds that only the treatment Petitioner received up to and including September 27, 2010, was causally related to Petitioner's subject work accident. The Arbitrator specifically finds that none of the treatment received following that date is causally related. The Arbitrator concludes that Respondent has paid all reasonable and related medical bills on or prior to September 27, 2010, as indicated in Respondent's exhibit number 6

K. What temporary benefits are in dispute?

The Arbitrator does not find credible, Petitioner's testimony that the Concentra doctor gave him work restrictions; and that Dr. Kornblatt did not conduct any examination upon him. Both of these doctors' records are contrary to Petitioner's testimony.

Based upon all the evidence, and giving the Petitioner the benefit of the doubt, the Arbitrator finds that the Petitioner is entitled to temporary total disability benefits from the date of Dr. Malas' first examination, i.e. August 23, 2010 until the September 27, 2010 date of Dr. Kornblatt's examination, a period of 5-1/7 weeks.

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

The Arbitrator finds the opinions of Drs. Cole and Kornblatt to be more persuasive than those of the other treating doctors. These doctors found that the Petitioner sustained a minor strain of his cervical spine and a right forearm contusion, both of which had completely healed by September 27, 2010.

The Arbitrator finds that Petitioner is entitled to 5% loss of use of his right arm, less a credit of 1.9% right arm (for prior settlement of 10 WC 32406) for a net award of 3.1% loss of use of right arm, and 1% loss of use of body as a whole for his cervical sprain.

15IWCC0638

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
10 WC 32404
SIGNATURE PAGE

L. Thompson Scott
Signature of Arbitrator

September 9, 2014
Date of Decision

SEP 8- 2014

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

Betty Meers,
Petitioner,

vs. NO: 14 WC 11384

GSI Group,
Respondent.

15IWCC0639

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 23, 2014 is hereby affirmed and adopted.

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 0 2015

Joshua D. Luskin

Charles J. DeVriendt

Ruth W. White

o-08/05/15
jdl/wj
68

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MEERS, BETTY
Employee/Petitioner

Case# **14WC011384**

GSI GROUP
Employer/Respondent

15IWCC0639

On 12/23/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.15% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0258 HELLER HOLMES & ASSOC
FRED JOHNSON
PO BOX 889
MATTOON, IL 61938

0771 FEATHERSTUN GAUMER POSTLEWAIT
DAN GAUMER
PO BOX 1760
DECATUR, IL 62525

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

BETTY MEERS
Employee/Petitioner

v.

GSI GROUP
Employer/Respondent

Case # 14 WC 11384

15IWCC0639

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 Molly Dearing**, Arbitrator of the Commission, in the city of **Urbana**, on **October 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 29, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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 accident, Petitioner earned **$26,598.00**; the average weekly wage was **$511.50**.

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

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

Respondent ***has*** paid all 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 benefits, and **$863.95** for nonoccupational indemnity disability benefits, for a total credit of **$863.95**.

ORDER

Because Petitioner failed to prove by a preponderance of the evidence that she sustained accidental injuries that arose out of and in the course of her employment on August 29, 2013 and because Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her work accident, benefits are denied.

Petitioner's Petition for Attorneys Fees and Penalties is denied.

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

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

Arbitrator Molly Dearing

December 18, 2014
Date

DEC 23 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

BETTY MEERS
Employee/Petitioner

v. Case # 14 WC 11384

GSI, INC.
Employer/Respondent

15IWCC0639

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, Petitioner was fifty nine years of age, and she was employed by Respondent as a wiring technician. She has been so employed since 1998. Petitioner's job duties include wiring control boxes for portable grain dryers. Petitioner utilizes a scissor table that slowly raises and lowers hydraulically by way of a foot pedal to allow employees to work in a sitting or standing position. Petitioner testified that she generally sits with one foot on a control box on the floor, which is about six inches high.

On August 29, 2013, the Petitioner was sitting on a swivel chair with her feet on a control box when she slowly lowered her table onto her left knee. Petitioner testified that she twisted to get up to get something when she realized that her left leg was pinned underneath the table. Petitioner was unable to reach the foot pedal to release the table and called her supervisor, Melissa Lindley, for assistance. Although Petitioner was equidistant to both Ms. Lindley and a co-worker, Sherry Hemrich, Petitioner testified that she specifically requested Ms. Lindley to assist her so that she could see the table on her leg to apprise her of the defect in the table. Ms. Lindley arrived shortly after Petitioner requested her assistance and pressed the pedal that raised the scissor table off of Petitioner's leg. Petitioner testified that her knee was tender immediately after the incident, and that she noticed swelling in her knee within two to three days. She treated the pain conservatively with ibuprofen and Icy Hot. Petitioner testified that her swelling continued to worsen thereafter, which prompted her to seek medical treatment on November 26, 2013 with Dr. Karl Rudert.

On November 26, 2013, Petitioner presented to Dr. Rudert at the Bonutti Clinic, at which time Petitioner reported that her left knee became "stuck between the top of the table and the bar and it pushed her knee down and she couldn't get it out." She denied injuring her right knee. Petitioner further reported that she had an indentation on her left knee from the pressure of the bar and swelling shortly thereafter. "She thought it was just old age and it would just go away." Petitioner was ordered to undergo physical therapy and an MRI, prescribed anti-inflammatory medication, and fitted with a brace. On January 28, 2014, Petitioner reported to Dr. Rudert that on August 29, 2013, she had her foot on a bar on a lift table and "the lift table came down and kind of guillotined her on the top of her patella. She has had pain off and on." The MRI of that date revealed a medial meniscus tear. Dr. Rudert referred her for an orthopedic evaluation. PX 3.

On March 26, 2013, Petitioner presented to Dr. Timothy Gray at the Bonutti Clinic and reported that her knee became trapped underneath a scissor table and she twisted her knee "when

she pulled [her left knee] out" from underneath the table. Petitioner "did not think it hurt it bad to start with but then changed departments. She does a lot more standing. She is having a lot more pain and irritation. The patient thought it was just a hematoma...It is still giving her pain and irritation. It is just not improving." On April 18, 2014, Dr. Gray performed a left knee arthroscopy and partial medial meniscectomy. Dr. Gray released her to return to work full without restrictions on May 12, 2014, and he released her to return on an as needed basis on June 6, 2014. PX 3.

At Arbitration, Petitioner testified that she presently has pain and difficulty with kneeling, and with rising from a squatting position. She also has difficulty with climbing stairs. Petitioner testified that prior to the accident, she twisted her knee regularly to get into a kneeling position to scrub her floors at home and to get into the floor to play with her grandchild. Since the accident, Petitioner testified that she utilizes her right knee primarily to get in and out of her pickup truck, and to get to get up from a kneeling position. She further testified that she is able to perform normal housework presently as she did before the accident, and she has continued to perform her regular work duties. Petitioner denied any difficulties in either of her knees prior to her work accident, and she denied seeking any medical treatment, taking any medications, or requiring any limitations in her left knee prior to August 29, 2013. Petitioner's husband, David Meers, testified at Arbitration, and confirmed that Petitioner had no left knee problems prior to her work accident. He testified that Petitioner continues to have swelling in her left knee, and difficulty getting up and moving around.

Melissa Lindley, Petitioner's supervisor, testified at Arbitration. She is employed by Respondent as a production supervisor. Ms Lindley testified that Petitioner called her to raise the scissor table because Petitioner was unable to reach the floor pedal. Ms. Lindley testified that when she arrived at Petitioner's station, the table was situated five to six inches above Petitioner's kneecap on her upper thigh area. Petitioner was calm and when Ms. Lindley inquired about what was the matter, Petitioner pointed to the table resting on her leg. After she released the table, Ms. Lindley testified that Petitioner rotated in her swivel chair and stood up. Upon standing, Petitioner indicated that she had some pain in her leg. Ms. Lindley confirmed that there was no discussion of Petitioner requiring medical treatment at that time. Ms. Lindley testified that she did not observe Petitioner struggle to extricate her leg from underneath the table, nor was there any indication of a struggle in light of Petitioner's calm demeanor. Ms. Lindley stated that in the weeks following the accident, she was in and out of Petitioner's work area approximately twelve times per day, and Petitioner did not indicate to her at any time that she continued to have problems with her left leg. Ms. Lindley testified that approximately three months after the accident, Petitioner approached her and requested medical treatment.

Sherry Hemrich testified at Arbitration by virtue of a subpoena. Ms. Hemrich was employed by SelectRemedy as a temporary employee and assigned to Respondent on August 29, 2013, and sat beside Petitioner on the date of accident. Ms. Hemrich testified that her desk and Petitioner's desk faced the same direction, and were situated four to five feet apart. Ms. Hemrich testified that she overheard Petitioner request assistance from her supervisor and overheard Petitioner state that she hoped Ms. Lindley would arrive quickly because she was beginning to hurt. Ms. Hemrich observed the table resting on Petitioner's thigh approximately five to six inches above her knee. Ms. Hemrich testified that Petitioner was seated in a swivel chair and stood up normally once the table was released off of her leg. Ms. Hemrich testified that she could see Petitioner out of the corner of her eye while working and she did not see Petitioner struggle to extricate herself from underneath the table on August 29, 2013 or twist or pivot in her seat before she requested assistance from Ms. Lindley, though she acknowledged that she did not observe Petitioner the entire time and did not

see when the table initially came into contact with her leg. Ms. Hemrich testified that her attention was originally drawn to Petitioner when Petitioner overheard Petitioner request assistance from Melissa Lindley and that Petitioner could have moved or twisted in the time she was not observing her. Ms. Hemrich testified that she was laid off from her assignment with Respondent in September 2014, and denied that Petitioner complained of soreness in her leg following the incident.

Dr. Gray testified by way of evidence deposition on September 16, 2014. Dr. Gray testified that upon presenting to him on March 26, 2014, Petitioner reported left knee complaints since August 2013 when she twisted her left knee while attempting to extricate it from underneath a scissor table. Petitioner denied any swelling in the knee on the date of incident and did not indicate to him that her knee had been painful since the accident, but indicated to Dr. Gray that she did not believe she sustained a major injury following her work accident and suffered some bruising. Dr. Gray testified that the twisting mechanism likely caused her left medial meniscus tear, and he stated that it was his understanding that Petitioner struggled to release her left leg from underneath the scissor table. Dr. Gray opined that, based upon her description of a lack of knee problems prior to the incident, an onset of problems afterwards, and given the type of trauma she described, that the work accident of August 29, 2013 caused the meniscal tear. Dr. Gray stated that a twisting mechanism is consistent with a medial meniscal tear, and he testified that if Petitioner did not twist her knee in this incident, her left knee problems are likely due to another cause. PX 3.

CONCLUSIONS OF LAW

In regard to disputed issue (F), the Arbitrator finds that Petitioner's current condition of ill-being is not causally related to the work accident. In so concluding, the Arbitrator finds the temporal disparity of approximately three months between Petitioner's work accident of August 29, 2013 and her first date of treatment on November 26, 2013 significant for a lack of a causal relationship between the work accident and her current left knee condition. Petitioner worked full duty during that three-month period of time without voicing any left knee complaints to either Ms. Hemrich or to her supervisor, Ms. Lindley, or seeking medical treatment.

In forming his causation opinion, Dr. Gray could not recall whether Petitioner informed him of how soon she sought treatment after her work accident and he testified that he did not have such information in his record. PX 3. Therefore, it appears that he was unaware of the three-month delay between Petitioner's work accident and her initial treatment visit when forming his causation opinion, which goes to the weight of his opinion.

Further, the basis of Dr. Gray's causation opinion, namely that Petitioner twisted her left knee while struggling to extricate it from underneath the scissor table (PX 3), is not supported by a preponderance of the credible evidence at Arbitration. Although Petitioner testified she reported to her physicians that she twisted her knee while struggling to free her left leg from underneath the table, Petitioner's treating records do not reflect that Petitioner gave a history of a twisting mechanism to Dr. Rudert or to her physical therapist, but instead indicate that Petitioner reported the table resting directly on her left knee caused her injury. PX 3, RX 1. Furthermore, Petitioner did not testify at Arbitration that she twisted her knee in an attempt to extricate it from underneath the table at Arbitration, as she reported to Dr. Gray, and instead testified that she "went to twist to get up to get something, and I realized my leg was pinned." Essentially, in the history given to Dr. Gray, Petitioner reported twisting her knee after she realized it was pinned while attempting to free her leg, whereas in her history given at Arbitration, she twisted before she realized that her leg was

caught. Not only does the history of accident proffered at Arbitration differ from that given to Dr. Gray, Petitioner did not testify at Arbitration as to what body part she twisted. The Arbitrator is disinclined to assume that Petitioner twisted her left knee, as the Arbitrator could equally infer that Petitioner twisted or otherwise rotated at her waist or with her entire body given that Petitioner was seated on a swivel chair at the time of the incident, which would be inconsistent with the mechanism of injury she reported to Dr. Gray and inconsistent with the mechanism of injury generally associated with a meniscal tear, per Dr. Gray's testimony. PX 3. Moreover, Petitioner testified at Arbitration that subsequent to August 29, 2013, she noticed tenderness, swelling, and "took Ibuprofen for the pain and the swelling and put Icy Hot on it to help relieve the pain." Yet, Dr. Gray testified that Petitioner did not report pain since the work accident, and she reported to Dr. Gray on March 26, 2014 that she did not believe she suffered an injury until she changed departments at work and began standing more frequently (PX 3), which is inconsistent with the injury Petitioner alleges at Arbitration.

Further, Ms. Hemrich credibly testified that she did not see Petitioner struggle to extricate her leg from underneath the table, which undermines Petitioner's history of injury reported to Dr. Gray. Although Ms. Hemrich acknowledged that she was not directly observing Petitioner during the entire incident, Ms. Hemrich witnessed the incident from the time Petitioner indicated she was beginning to hurt, she could see Petitioner in her peripheral vision, and she was in a position to see Petitioner had she struggled. Ms. Hemrich testified that she was seated within four to five feet of Petitioner and in a similar position to Petitioner at Arbitration as she was at the time of the accident, and having observed the seating positions and proximity between the two, the Arbitrator finds that Ms. Hemrich was in an excellent position to observe any struggle or extraordinary effort of Petitioner to extricate her leg from underneath the table. Despite her proximity, Ms. Hemrich denied seeing Petitioner struggle to free her leg or pivot in her swivel seat before requesting assistance, and Ms. Hemrich's testimony is supported by Ms. Lindley's credible testimony that she too did not observe Petitioner struggle to extricate her leg from underneath the table, as well as Ms. Lindley's testimony that Petitioner was calm when she arrived at her work station to assist her.

The Arbitrator notes that although Petitioner testified to a lack of left knee complaints prior to the work accident and an onset of complaints thereafter, the Arbitrator finds the aforementioned evidence undermines Petitioner's alleged chain of events, and the finding of any causal relationship between her work accident and her left knee condition. Based upon the foregoing, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the credible evidence that her current condition of ill-being in her left knee is causally related to her work accident.

In regard to disputed issue (C), the Arbitrator concludes that Petitioner did not sustain accidental injuries arising out of and in the course of her employment on August 29, 2013. In so concluding, the Arbitrator notes the inconsistencies between the histories of accident Petitioner proffered at Arbitration with those given to her treating physicians, as well as the credible testimony of Ms. Hemrich and Ms. Lindley that undermines Petitioner's history of accident given to Dr. Gray, discussed further above.

In light of the Arbitrator's foregoing conclusions, the Arbitrator concludes that Petitioner failed to establish entitlement to penalties or attorney fees under Sections 19(k) and 19(l) or 16 of the Act, and the Arbitrator accordingly denies Petitioner's Petition for Attorney Fees and Penalties. The remaining issues of medical benefits, temporary total disability benefits, and permanent disability benefits are moot, and the Arbitrator accordingly makes no conclusions as to those issues.

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 Causal connection	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

NANETTE SCHROEDER,

Petitioner,

15IWCC0640

vs.

NO: 14 WC 03251

SWIFT TRANSPORTATION,

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(s) of causal connection, medical expenses and TTD and being advised of the facts and law, reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof, as stated below and 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 Decision of the Arbitrator was that Petitioner failed to prove her condition of ill-being was causally related to her December 19, 2013, accident. It was also found that Petitioner failed to prove that her accident arose out of and in the course of Petitioner's employment. The Decision of the Arbitrator found Petitioner experienced a temporary aggravation of a pre-existing degenerative disc disease in her lumbar spine and not the continuing symptomatic condition as she claims. The Commission disagrees and finds the condition Petitioner complained of at the time of her arbitration hearing to be the result of her December 19, 2013, accident.

It is not disputed that Petitioner's lumbar spine showed evidence of degenerative changes prior to her December 19, 2013, accident. The Decision of the Arbitrator noted, "Dr. Yazbak, [Petitioner's treating physician], indicated that he was 'very concerned about the evolving and substantial breakdown at L5-S1'" and of the x-rays taken of Petitioner's lumbar spine on March

20, 2013, that revealed "increasing severe degenerative disc disease [at] L5-S1." The Arbitrator also failed to note that Petitioner continued to work full duty, at her regular job, despite her pre-existing lumbar condition, as was diagnosed by Dr. Yazbak, through the date of her work accident.

"A chain of events which demonstrate a previous condition of good health, an accident and subsequent injury resulting in disability may be sufficient circumstantial evidence to prove a causal nexus between the accident and the employee's injury." *Shafer v. Illinois Workers' Compensation Commission,* 976 N.E.2d 1, 12, 364 Illl. Dec. 1, 20 Il. App. (4th) 100505WC. In Petitioner's case, the above quote would have to be modified to read "relative good health" given the condition of her lumbar spine. It is not disputed, however, that Petitioner was still capable of working full-time in a full-duty capacity up until the time of her accident. Petitioner's inability to continue to do so after her accident is the circumstantial evidence the court in *Shafer* contemplated as being sufficient for a finding of causal connection.

The arbitrator relied on Dr. Babak Lami's interpretations of the pre- and post-accident radiographic imaging to conclude that there was only a temporary aggravation of Petitioner's pre-existing condition. By this reliance, the arbitrator refused to find a causal relationship between the accident and Petitioner's post-accident condition of ill-being. This finding was only made as Dr. Lami conceded that there was pain associated with the accident but concluded that the pain was transient in nature. This conclusion belies the fact that the pain never subsided.

Petitioner's treatment of her lumbar spine ended approximately nine months prior to her accident. The date of that treatment was March 20, 2013, and the treatment consisted of Petitioner undergoing x-rays of her lumbar spine. There is no record of Petitioner seeking any further treatment for her lumbar spine until January 6, 2014, seventeen days after the date of her accident. From that date through October 15, 2014, Petitioner was seen by Dr. Yazbak on a fairly regular basis. Given the testimony of Petitioner and Dr. Yazbak and the medical records, the Commission is satisfied that Petitioner's current complaints of ill-being, with respect to her lumbar spine, are the result of Petitioner's December 19, 2013, accident.

The Commission, however, is not convinced that the seizure she testified to experiencing and the subsequent treatment she underwent following it with a Dr. Jaffri was causally connected to her treatment for her lumbar spine. Petitioner testified that, according to Dr. Jaffri, her seizure might have been brought on by the medication she was taking to treat her back. Petitioner then identified the potentially offending medication as Tramadol. Dr. Yazbak also attributed Petitioner's seizure to Tramadol but acknowledged that he was unaware of any incidences of seizures relatable to Tramadol.

The Commission is not satisfied with Dr. Yazbak's finding that Petitioner's seizure was due to Tramadol, as he was unaware of any other seizures being brought on by its usage. Dr. Yazbak's position, on this issue, strikes the Commission as too convenient and not credible. The Commission, accordingly, finds Petitioner failed to prove that her seizure and the subsequent treatment for it was causally related to her December 19, 2013. All charges stemming from the seizure are personal to Petitioner.

15IWCC0640

By her Review, Petitioner also seeks to have the Commission issue an order requiring Respondent to draft a vocational rehabilitation plan as set forth under Rule 7110.10 of the Rules Governing Practice before the Illinois Workers' Compensation Commission. Rule 7110.10 states an employer shall prepare a written assessment of the course of medical care and, if appropriate, rehabilitation when it becomes apparent either that the injured worker cannot return to the regular duties engaged in at the time of injury or when the injured worker's period of total incapacity exceeded 120 continuous days, which ever come first. In Petitioner's case, the 120 continuous days of total incapacity came first. Although mandated by the Rules, the Commission finds the need for a vocational assessment was overtaken by other events and made unnecessary.

The vocational assessment, as predicated by Rule 7110.10, requires Respondent to prepare a written assessment of medical care. Petitioner testified that she last treated the symptoms caused by her December 19, 2013, accident on October 15, 2014, in the form of a visit to Dr. Yazbak. As a result of that visit, Petitioner was released from Dr. Yazbak's care with permanent restrictions. As the course of Petitioner's medical care has concluded, the Commission finds it unnecessary to require Respondent to prepare a written assessment of Petitioner's medical care.

Further, the Commission finds a vocational assessment is not necessary given Petitioner's ability to return to work in the same capacity as she had prior to her accident. As of the date of the arbitration hearing, October 28, 2014, Petitioner, through her own testimony, indicated that she is open to returning to a career as a commercial driver but claimed to be unable to return to a career as an over-the-road truck driver. However, she provided no evidence that she could not return to such a career. Just prior to the arbitration hearing, on October 15, 2014, Dr. Yazbak released Petitioner to work with permanent restrictions of working in a medium physical demand level, with lifting restrictions of lifting no more than 50 pounds frequently and carrying items weighing more than 25 pounds. No restriction was placed on the length of time Petitioner could sit, and none was placed on Petitioner's ability to drive a semi-tractor trailer.

The Commission notes that no testimony or medical opinion was offered that indicated that driving a semi-tractor trailer would require Petitioner to work outside of Dr. Yazbak's imposed restrictions. Any difference between duties of an over-the-road driver and the duties Petitioner testified to performing prior to her accident are found to be minimal, especially given there being no testimony of her pre-accident activities including loading freight into a container.

The Commission finds Rule 7110.10 to prescriptive but only necessary when the injured worker is in need of an assessment for medical care and, if necessary, vocational rehabilitation. In the present case, Petitioner's recovery from the injuries sustained in her December 19, 2013, accident was so rapid that it outpaced the necessity of an assessment for medical care and so complete that it allowed for her to resume her career as an over-the-road truck driver, though Petitioner expressed a preference to work as a part-time local driver.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator as it pertains to the causal connection to Petitioner's December 19, 2013, accident and her current condition of ill-being is reversed.

15IWCC0640

IT FURTHER ORDERED BY THE COMMISSION that Petitioner failed to prove that her seizure and resultant treatment was causally connected to her December 19, 2013, accident.

IT IS FURTHER ORDED BY THE COMMISSION that Respondent need not provide Petitioner with a written assessment to address the course of medical care and vocational rehabilitation.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision to address the duration of TTD benefits, medical expenses, credit under Section 8(j) of the Act and the nature and extent of permanent disability, 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 $100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 20 2015
KWL/mav
O: 06/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0640

SCHROEDER, NANETTE
Employee/Petitioner

Case# **14WC003251**

SWIFT TRANSPORTATION
Employer/Respondent

On 12/9/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.09% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
STEPHEN J SMALLING
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

0000 LEWIS RICE & FINGERSH LC
DUANE L COLEMAN
600 WASHINGTON AVE SUITE 2500
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF McClean)

☐ 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)

15IWCC0640

Nanette Schroeder
Employee/Petitioner
v.

Case # 14 WC 3251

Swift Transportation
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Bloomington**, on **October 28, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 19, 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 not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**30,856.02**; the average weekly wage was $**593.79**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of $**7,912.00** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**7,912.00**.

Respondent is entitled to a credit of $**49,562.14** under Section 8(j) of the Act.

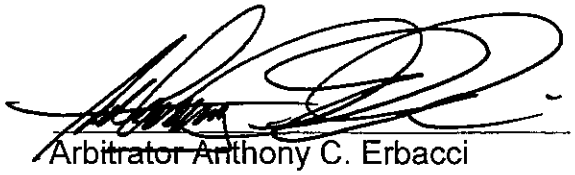
ORDER

The Arbitrator has found that the Petitioner has failed to meet her burden of proof with regard to the issue of causation, therefore, the Petitioner's claim for compensation is denied and no benefits are awarded herein.

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

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

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



Arbitrator Anthony C. Erbacci

December 1, 2014
Date

DEC 9 - 2014

FACTS:

On December 19, 2013, the Petitioner was employed with the Respondent as an over the road truck driver. The Petitioner testified that she obtained her commercial driver's license in 2005 and was then employed by the Respondent to haul freight in the continental United States. The Petitioner testified that after she worked for the Respondent for five or six months, she quit that job and went to work as a driver for another trucking company. She testified that she quit that job in 2006 and that she was then unemployed until late May 2013, at which time she was re-hired by the Respondent.

The Petitioner testified that during the period of her unemployment, she underwent two surgeries to her back, one in 2009 and one in 2011, and she was also diagnosed with fibromyalgia. The Petitioner testified that she has been receiving Social Security Disability benefits due to her fibromyalgia condition from 2010 through the present time.

The Medical records admitted into the record demonstrate that in 2009 the Petitioner underwent an anterior lumbar interbody fusion at the L4-L5 level, performed by Dr. Praycek. In April 2011, the Petitioner was referred by Dr. Michael Fetterolf to the Neuroscience Group in Neenah, Wisconsin where she was diagnosed with fibromyalgia and a bulging disc at L5-S1. The Petitioner also reported "stabbing pain" in her entire back at that time. On May 22, 2011, the Petitioner was taken by ambulance to Theda Clark Medical Center in Neenah, Wisconsin, where she underwent a second operation on her back. Specifically, Dr. Thomas Wascher performed a left L5-S1 discectomy. Following the second surgery, the Petitioner continued to report ongoing low back discomfort and pain, as well as tingling and numbness in her left lower extremity. Accordingly, on June 8, 2011, she underwent an L5 nerve block by Dr. Schultz.

In 2012 and early 2013, the Petitioner continued to follow up at the Neuroscience Group for her fibromyalgia. At each of those visits, the Petitioner was noted to have complaints of numbness in her left lower extremity after the surgery with Dr. Wascher. Due to her complaints of increased pain, a lumbar MRI was ordered for the Petitioner and completed on February 27, 2013. On March 7, 2013, Dr. Albino performed a left S1 nerve root block on the Petitioner.

On March 20, 2013, the Petitioner returned to the Neuroscience Group and she was examined by Dr. Philip Yazbak. Dr. Yazbak noted that the Petitioner's lumbar MRI of February 27, 2013 demonstrated evidence of postoperative changes from an anterior fusion at L4-5 with integral screws and postoperative changes on the left at L5-S1 in the area of the Petitioner's prior discectomy. Dr. Yazbak also noted that, despite the prior discectomy, there was still a substantial ridge at that site which seemed to be large enough to compromise the left S1 nerve root, but not really the L5 nerve root. It was

also noted that the L5-S1 disk showed substantial loss of normal disk signal, loss of normal disk height, and endplate changes, which constituted a major difference as compared to the MRI performed in May 2011.

Dr. Yazbak noted that he was concerned that the Petitioner was 40 years old and had already had 2 back surgeries and that he was very concerned about "the evolving and substantial breakdown at L5-S1". Dr. Yazbak ordered x-rays of the Petitioner's lumbar spine to rule out a dynamic instability and he indicated that if there was abnormal motion in the Petitioner's spine he would recommend a fusion as opposed to a simple discectomy. He indicated that as the majority of the Petitioner's pain was buttock and leg pain, if the x-rays were normal, he would recommend a repeat discectomy on the left L5-S1 and leave the back pain to be treated with core strengthening and anti-inflammatories. .

X-rays of the Petitioner's lower back taken on March 20, 2013 revealed "progression of severe disc space narrowing at L5-S1 and it was noted that the Petitioner had "increasing severe degenerative disc disease L5-S1."

On March 25, 2013, the Neuroscience Group recognized that the Petitioner was a candidate for either another discectomy or fusion surgery at the L5-S1 level. On April 22, 2013, the Petitioner called the Neuroscience Group and indicated that she was ready to proceed with whatever surgical procedure would be indicated. The Petitioner was noted to have reported that she had constant, stabbing, throbbing pain in her lower back with radiation into her left hip, which she rated at 8/10. On April 23, 2013, Dr. Yazbak noted that when he had last seen the Petitioner she advised that 2/3 of her pain was in her butt and leg but that, after reviewing the April 22, 2013 note, he believed she now had more back pain than leg pain."

On April 29, 2013, the Petitioner reported that her lower back pain had gotten much worse since she saw Dr. Yazbak. That same day, Dr. Yazbak authored a note indicating that, "given the preponderance of LBP [low back pain], would rec fusion -- I will put thru scheduling in near future." In May and June 2013, Neuroscience Group attempted to schedule fusion surgery for the Petitioner but the Petitioner ultimately opted not to have the surgery due to some other medical issues and her desire to go back to work driving a truck.

In May 2013, the Petitioner re-applied to work for the Respondent and she was hired on May 30, 2013. Before she was hired, the Petitioner underwent a medical examination to determine her fitness as a commercial driver. As part of the examination, the Petitioner completed the first two sections of a "Medical Examination Report," which requested her personal information and health history. The Petitioner disclosed that in 2011 she had a back surgery performed by Dr. Wascher, but she did not disclose her fusion surgery in 2009. The Petitioner also did not disclose that she had severe degenerative disc disease for which surgery had just been recommended. She also failed to identify Dr. Yazbak, as her treating physician.

On December 20, 2013, the Petitioner was dispatched by the Respondent to deliver a load to a Wal-Mart store in Sterling, Illinois. After unloading her truck and securing a signature on some paperwork, the Petitioner slipped on some ice and fell while walking back to her truck. The Petitioner testified that she immediately noticed pain in her back and her left hand, wrist, and elbow. The Petitioner reported the incident to the Respondent and was directed to seek medical treatment. The Petitioner went to CGH Medical Center in Sterling that same day and underwent x-rays of her left hand, wrist and elbow, and her lumbar spine. All the x-rays were reported to be negative for fractures and the Petitioner was discharged with an arm sling, a wrist splint, and instructions to follow up with her primary care physician.

On December 30, 2013, the Petitioner saw Dr. Tamara Daniels at Theda Clark Medical Center in Neenah, Wisconsin. Dr. Daniels reviewed the x-rays of the Petitioner's lumbar spine taken at CGH Medical Center and noted there was no fracture. The Petitioner reported that her back pain was non-radiating and she was found to have "normal sensation to lower extremities bilaterally." The Petitioner was noted to exhibit tenderness in her lumbar back in the area of L4-L5, but normal range of motion, no swelling, no edema, no deformity, no laceration, no pain, no spasm and normal pulse. The Petitioner was prescribed Flexeril and Vicodin for back pain and was discharged.

On January 6, 2014, the Petitioner returned to Dr. Yazbak who noted that the Petitioner had opted not to have the previously recommended L5-S1 decompression with TLIF and fusion due to some other medical issues and her desire to get back to work driving a truck. Dr. Yazbak also noted that he had reviewed the most recent x-rays and that they showed no changes versus the x-rays taken in March. Dr. Yazbak noted that the Petitioner had an absolutely mature fusion at L4-5 with severe degeneration at L5-S1 that had clearly progressed as compared to prior x-rays and MRIs. Dr. Yazbak also prepared a letter to the Respondent indicating that the Petitioner was totally incapacitated at the time due to "degeneration of lumbar or lumbosacral intervertebral disc."

On January 14, 2014, the Petitioner was given facet joint injections at the L5-S1 level and, on January 24, 2014, she reported that the injections did not improve her pain. As a result, a lumbar MRI was ordered. On February 17, 2014, the Petitioner consulted with Dr. Yazbak and indicated that she wanted to proceed with surgery. Dr. Yazbak prepared another letter to the Respondent stating that the Petitioner was incapacitated due to "degeneration of lumbar or lumbosacral intervertebral disc."

On February 21, 2014, the Petitioner underwent an MRI of her lumbar spine which was reported to be "unchanged" compared to the prior MRI done at the Neuroscience Group on February 27, 2013.

On April 7, 2014, the Petitioner was examined by Dr. Babak Lami at the request of

the Respondent. Dr. Lami noted the Petitioner's fall on December 19, 2013 and that her medical records demonstrated that that she had significant back problems for which a surgery was offered to her before the fall. He noted that the Petitioner's MRIs and x-rays prior to and after the fall demonstrated no changes and that there was no disc herniation, fracture, or traumatic finding. Dr. Lami also noted that the Petitioner's neurologic examination was normal. Dr. Lami diagnosed the Petitioner as having chronic low back pain status post multiple previous spinal surgeries. Dr. Lami opined that it was possible that the Petitioner's fall had increased her pain, but that this should be fairly self-limiting and transient acute pain. Dr. Lami also opined that given her long prior back problems, he could not relate the Petitioner's current symptoms to the fall in question. Dr. Lami opined that the Petitioner did not require any further diagnostic testing as a result of the December 19, 2103 fall and that, while the recommended fusion at L5-S1 was reasonable medical treatment, the recommendation for a spinal fusion surgery was not related to the fall in question. Dr. Lami further opined that the Petitioner was at maximum medical improvement from her injury and could return to work without any restriction as a result of the December 19, 2103 fall.

On April 10, 2014, the Petitioner underwent an L5-S1 anterior lumbar interbody fusion with locking screws and allograft chips performed by Dr. Yazbak. On May 30, 2014, the Petitioner followed up with Dr. Yazbak and reported that she had the same left hip and low back pain as before her surgery. The Petitioner underwent a post-operative course of rehabilitation and therapy and was ultimately discharged from Dr. Yazbak's care on October 20, 2014 subject to permanent restrictions. Dr. Yazbak opined that the Petitioner would experience periodic flare ups of her symptoms and that she was unable to perform her regular job functions and could only work on a part time or reduced schedule. Dr. Yazbak opined that the Petitioner's pre-existing condition changed for the worse following her accident and "prompted moving in a surgical direction".

The Petitioner testified that she currently continues to experience pain in her back as well as numbness in her left leg and toes. She testified that she now walks with a limp and that her left leg gives out on occasion causing her to trip. The Petitioner testified that she also experiences pain in both of her hips.

The Petitioner testified that she was "terminated" by the Respondent on September 16, 2014, and that no offer of employment within her restrictions was extended to her. She also testified she cannot return to over the road truck driving, but wants to be a dispatcher in the trucking industry. The Petitioner further testified she recently applied for work through an online portal and is waiting to hear back from prospective employers.

CONCLUSIONS:

In Support of the Arbitrator's Decision relating to (C.), Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that she was employed as an over the road truck driver for the Respondent. On December 19, 2013, she was directed to Walmart by the Respondent to deliver a load. Walmart designated the area in which she was to park her truck. After exiting the truck and speaking with Walmart personnel, the Petitioner slipped on black ice and fell to the ground as she was walking back to her truck. She immediately noted pain in her back and contacted the Respondent who directed her to seek medical attention and instructed her to stay in the area. The Petitioner was examined that night at CGH Medical Center in Sterling, Illinois. The Petitioner's testimony regarding her accidental injury was not contradicted, and was corroborated by the medical records of her initial treatment.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that an accident occurred that arose out of and in the course of Petitioner's employment by the Respondent.

In Support of the Arbitrator's Decision relating to (F.), Is Petitioner's current condition of ill-being causally related to the injury, the Arbitrator finds and concludes as follows:

It is clear from the record that the Petitioner had a long history of severe degenerative disc disease in her lower back prior to her slip-and-fall accident in December 2013. In addition to undergoing back operations in 2009 and again in 2011, the Petitioner had numerous injections before the accident for purposes of alleviating the ongoing pain she was experiencing in her lower back, left hip and leg. A third back surgery, a fusion of the L5-S1 vertebrae, was also recommended to the Petitioner in the spring of 2013. At that time, Dr. Yazbak indicated he was "very concerned about the evolving and substantial breakdown at L5-S1" and the x-rays of Petitioner's lumbar spine taken on March 20, 2013 showed "increasing severe degenerative disc disease L5-S1."

The objective medical evidence also reflects that the condition of the Petitioner's lower back was "unchanged" following her accident. Numerous x-rays and MRIs of Petitioner's lumbar spine were taken before and after the accident. All the doctors involved, including the Petitioner's own treating physician and surgeon, Dr. Yazbak, concur that the post-accident x-rays and MRIs revealed no changes. Dr. Yazbak also acknowledged that the Petitioner's work accident did not cause any structural changes to the Petitioner's lower back.

The Arbitrator finds it to be significant that the surgery Dr. Yazbak performed on April 10, 2014 was the same surgery (an L5-S1 fusion) he recommended to Petitioner, and endeavored to schedule for her, prior to her work accident. The surgery was necessitated not as a result of the work accident but, rather, it was recommended for the Petitioner prior to her

work accident as a result of her increasing, pre-existent, severe degenerative disc disease. This is particularly evident in view of the fact that the diagnostic films taken after the accident revealed no changes in the condition of the Petitioner's lumbar spine.

The Arbitrator does not find it to be significant that Dr. Yazbak performed the L5-S1 fusion surgery in a different manner than he had originally contemplated before the accident. He testified the surgery was done a different way because the Petitioner's complaints of pain after the accident shifted over to a preponderance of back symptoms as opposed to leg symptoms. This testimony, however, seems to be contradicted by Dr. Yazbak's records of April 23 and April 29, 2013 which indicate that, as of that time, the Petitioner had a preponderance of low back pain. The Petitioner had the same complaints of pain after the accident.

The report and opinions of Dr. Lami are also persuasive. Dr. Lami had the Petitioner's actual diagnostic films, and his report reflects that he reviewed the Petitioner's medical records and conducted a physical examination of the Petitioner. Significantly, Dr. Lami's report states that Petitioner's "MRIs and x-rays prior to and after the fall in question demonstrate no changes," and his report further states, "[t]here is no disc herniation, fracture, or traumatic finding." Dr. Lami's finding in this regard was not controverted by any medical evidence offered into the record.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's work injury of December 19, 2013 resulted in a temporary aggravation of her pre-existing low back condition. The Arbitrator further finds that the Petitioner failed to prove that the need for the surgery performed by Dr. Yazbak was causally related to her work injury and failed to prove that her current condition of ill-being is causally related to her work injury.

As the Arbitrator has found that the Petitioner has failed to meet her burden of proof with regard to the issue of causation, determination of the remaining disputed issues is moot. The Petitioner's claim for compensation is denied and no benefits are awarded herein.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA HARVEY,

Petitioner,

15IWCC0641

vs.

NO: 12 WC 44630

DODDS CUSD #7,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, 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, 35 Ill.Dec. 794 (1980).

With regard to the issue of medical expenses related to Petitioner' left forearm contusion, the Commission modifies the Arbitrator's award of medical expenses to include the medical charges of Dr. Amarado, which total $ 256.00. As noted by the Arbitrator, following Petitioner's October 26, 2010 slip and fall, she was diagnosed with a left elbow contusion at St. Mary's Good Samaritan Hospital, and was then seen in follow up by Dr. Jose Amorado on November 1, 2010, November 5, 2010, and November 15, 2010. (PX3,PX4). Petitioner tendered into evidence the billing statement of Dr. Amorado for those three dates of service, which total $256.00. (PX1). The Commission awards those charges totaling $256.00, and further finds the additional medical

expenses claimed by Petitioner are not causally connected to her October 26, 2010 left elbow injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 2, 2014, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $1,419.00 for medical expenses under §8(a) and pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,500.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 20 2015
KWL/kmt
O-6/23/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0641

HARVEY, DEBRA
Employee/Petitioner

Case# 12WC044630

12WC044496

DODDS CUSD #7
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
#6 EXECUTIVE DR
SUITE 3
FAIRVIEW HTS, IL 62208

2674 BRADY CONNOLLY & MASUDA PC
NOAH HAMANN
705 E LINCOLN ST SUITE 313
NORMAL, IL 61761

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0641

Debra Harvey
Employee/Petitioner

v.

Dodds CUSD #7
Employer/Respondent

Case # 12 WC 44630

Consolidated cases: 12 WC 44496

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 **Belleville**, on **6/19/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS. 15IWCC0641

On the date of accident, **10/26/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,920.00**; the average weekly wage was $**460.00**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Petitioner has only demonstrated evidence of a left forearm injury resulting from the October 26, 2010 accident. There is no evidence of a low back injury resulting from this accident.

Medical benefits for a back injury are denied.

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

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

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

Carl Lee 8/20/14

Signature of Arbitrator Date

ICArbDec19(b)

SEP 2 - 2014

Debra Harvey,
Petitioner,
v.

Dodds CUSD #7,
Respondent.

15IWCC0641

No. 12 WC 44630

FINDINGS OF FACT

Petitioner's Testimony

The petitioner is claiming injuries to her low back and left arm following a slip and fall on October 26, 2010. The petitioner works as a school cook. She testified that on October 26, 2010 she did not see a puddle of water on the floor. She testified that she stepped in the puddle, slipped and landed awkwardly on her back striking her left forearm on an object. She testified that as a result of this accident, she has continued pain in her left arm and low back.

The petitioner testified that she did not miss any work as a result of this accident. The petitioner testified that she was able to perform her job functions fully following the October 26, 2010 accident until sustaining a subsequent work accident on October 24, 2012, which is being addressed in a separate proposed decision for 12 WC 44496.

Medical Treatment

Medical records show that on October 26, 2010, the petitioner presented to the emergency room at St. Mary's Good Samaritan Hospital with complaints of left shoulder and elbow pain. (Rx1). She stated that when she landed she hit her elbow on the ground. X-rays were taken of the elbow and shoulder which were normal. She was diagnosed with an elbow contusion. No complaints were made concerning back pain. No treatment was rendered for her back.

The petitioner followed up with her primary care physician Dr. Jose Amorado on November 1, 2010. (Rx2). The history she gave was that she fell at work and hit her left forearm on a table leg. She was again diagnosed with a forearm contusion.

The petitioner followed up with Dr. Amorado two additional times on November 5, 2010 and November 15, 2010. (Id.). She was given an Ace wrap and pain medication. A 2 cm size nodule of swelling developed on the arm. Dr. Amorado suspected the petitioner may have torn some muscle fiber in her forearm.

The petitioner was referred to orthopedic specialist Dr. Joon Ahn at the Orthopedic Center of Illinois. (Rx3). The petitioner was examined by Dr. Ahn on November 22, 2010. The petitioner was noted to have a laceration and a large ecchymotic area on the left forearm. A 2 cm knot was observed in the petitioner's left forearm. Dr. Ahn opined that the petitioner was normal structurally but that there probably was some tear of a muscle fiber in the forearm. Dr. Ahn recommended physical therapy. The petitioner never participated in physical therapy.

The petitioner did not treat for left arm pain subsequent to November 22, 2010. She cancelled appointments with Dr. Ahn on December 20, 2010, September 19, 2011 and October 3, 2011. (Rx3).

The petitioner did not present any witnesses at the time of trial to discuss her complaints, deficits or functional limitations.

CONCLUSIONS OF LAW

F. Whether petitioner's present condition of ill-being is causally related to the accident?

The Arbitrator finds that as a result of the October 26, 2010 accident, the petitioner sustained a laceration to her left forearm and some tearing of muscle fiber in the forearm. The Arbitrator finds no causal connection between the petitioner's allegations of low back pain and the October 26, 2010 work accident.

Medical records do not show any evidence of treatment for low back pain following the October 26, 2010 work accident. The petitioner's treatment was limited only to the left forearm. The Arbitrator finds the petitioner's testimony about continued complaints of low back following

the October 26, 2010 work accident not to be credible and not supported by any medical evidence.

Additionally, the Arbitrator does not find the petitioner's testimony about continued left forearm pain following the October 26, 2010 accident up to the date of trial to be credible. Records show that the petitioner treated conservatively through November 22, 2010 for the left forearm, but otherwise, the petitioner did not treat subsequently. This demonstrates that the petitioner was not symptomatic.

Additionally, the petitioner continued to work full duty following the date of accident and did not need to miss work until the subsequent October 24, 2012 work accident which is the subject of 12 WC 44496. The petitioner's full duty status is evidence of a resolved left forearm injury.

The petitioner was seen for a Section 12 examination by orthopedic physician Dr. Frank Petkovich on February 22, 2013. The history taken by Dr. Petkovich from the petitioner concerning the October 2010 accident did not mention any back pain. Moreover, Dr. Petkovich opined, "it is my opinion that no further specific treatment is indicated for Ms. Harvey as a result of the above incident that she described as occurring while at work on October 26, 2010." (Rx4, pg. 7).

The petitioner furnished no causal connection opinion linking the 2010 accident to any low back pain or any condition of ill-being for that matter. Without a medical opinion linking the petitioner's conditions of ill-being to the October 2010 accident, no finding can be rendered in the petitioner's favor. Village of Oreana v. Industrial Commission, 289 Ill.App.3d. 682 NE 2d 1158 (1997).

Accordingly, the Arbitrator does not find a causal connection between the petitioner's low back condition of ill-being and the October 26, 2010 work accident.

J. Were the medical services that were provided to the petitioner reasonable and necessary? Has respondent paid all appropriate charges for all reasonable and necessary medical services?

Given that the Arbitrator does not find any causal connection between the petitioner's 2010 work accident and her low back condition of ill-being, all bills pertaining to the petitioner's low back are hereby denied. The petitioner is awarded bills related to the left arm which are as follows:

1. 10/26/10 – St. Mary's Good Samaritan Hospital x-rays of left shoulder and elbow totaling $1,163.00.

All other bills are denied.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DEBRA HARVEY,

Petitioner,

15IWCC0642

vs.

NO: 12 WC 44496

DODDS CUSD #7,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, 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, 35 Ill.Dec. 794 (1980).

With regard to the issue of causal connection, the Commission modifies the Arbitrator's decision to find that Petitioner current condition of ill-being with regard to her lumbar spine is causally related to her October 24, 2012 work-related injury. In so finding, the Commission finds that Petitioner credibly testified consistent with her medical histories, and that the medical evidence and witness testimony supports a finding that Petitioner's work related low back injury on that date while lifting a 100 pound folding table resulted in a significant change in her lumbar spine condition.

A review of the record reflects Petitioner admitted to her treating and examining physicians that she had suffered from low back symptoms prior to October 24, 2012. Petitioner testified that Dr. Amorado had recommended she follow up with Dr. Steinke, an orthopedic surgeon, for her low back symptoms prior to her October 24, 2012 work injury, but that she had not seen him or undergone physical therapy as of the date of her accident. Petitioner further testified that after the table lifting incident at work she had totally different low back pain from that which she had in the past. (T20-22). Petitioner testified that following her October 24, 2012 work injury she had low back pain, unbearable pain below her knee. Petitioner admitted she had low back pain radiating to her right buttock before October 24, 2012, and that she saw Dr. Amarado for back pain one week before her work accident, but that it did not compare to the pain she had following that October 24, 2012 work accident. (T33-35).

The Commission does not believe that Petitioner's testimony and the accident descriptions she provided to her medical providers were inconsistent. A review of the record indicates Petitioner's history of injuring her low back while lifting a table with a co-worker did not change throughout the medical records. The Commission is of the opinion that any minor additional details that were recorded by some of her medical providers, including that she twisted awkwardly and that the table was falling at the time of her work accident, were immaterial.

In further support of the Commission's finding that Petitioner's current low back condition is causally related to her October 24, 2013 work injury, the Commission relies upon the more persuasive opinions of Dr. Gornet and Dr. Raskas, both who evaluated and treated Petitioner, and offered favorable causation opinions. Dr. Gornet testified that: 1) Petitioner's current symptoms were causally connected to her October 24, 2012 work injury; 2) that Petitioner sustained an aggravation of her preexisting low back condition; and, that 3) Petitioner's need for surgery was based upon an aggravation of her preexisting condition, as she was working full duty until the October 24, 2012 work accident, which changed the quality of her life and affected her significantly. (PX12, T13-17).

Dr. Raskas testified that Petitioner provided a history of lifting a 100 pound pop-up table, which started to fall, and that she twisted and caught herself, but did not hit the floor. He further testified that Petitioner's October 24, 2012 work injury aggravated her condition, based upon her ability to work full duty, albeit with back problems, up until her work accident. Afterwards she was not been able to function fully in her job. Dr. Raskas further testified the mechanism of injury described by Petitioner was consistent with the injury Petitioner had, degenerative disc disease, a herniated disc at L3-4, and scoliosis.

Dr. Raskas further testified that prior to Petitioner's November 07, 2013 L3-4 transforminal lumbar interbody fusion surgery, he found no evidence that her low back condition had returned to baseline or to a pre-injury status despite physical therapy and injections. (PX13, T5-13). With regard to the contrary causal connection opinions rendered by Drs. Lange and Petkovich, the Commission finds their opinions that Petitioner only sustained a temporary

aggravation are not credible as Petitioner continued to be symptomatic months after the October 24, 2012 date of injury.

The Arbitrator found Petitioner less than credible. The Arbitrator relied on Petitioner's failure to seek immediate treatment despite her testimony as to having immediate severe pain and symptoms, and Petitioner's failure to report her injury until the Monday following her date of accident. The Commission finds the record does not support the Arbitrator's lack of credibility finding.

Although Petitioner did not report her October 24, 2012 work related injury until October 29, 2012, Petitioner testified, un-rebutted, that Mr. Craig Clark, her supervisor, was not present at the end of the school day on the date of accident as he was at a conference, that the nurse was not present at that time, and that school was closed the Thursday and Friday following her injury. Petitioner further testified that she reported her accident the minute Mr. Clark walked into work that Monday, October 29, 2012, at approximately 7:45 a.m., after which time she filled out an accident report. Petitioner further testified that she waited until Monday to report her injury, hoping her condition would improve over the long holiday weekend. (T28-33)

Mr. Clark was called to testify by Respondent, and confirmed that school was out the Thursday and Friday following her work related injury. Mr. Clark failed to rebut Petitioner's testimony that he, Clark, was not present at the end of the school date on the date of accident, and confirmed that Petitioner reported her accident on Monday, October 29, 2012. (T45-46). The Commission finds Petitioner's five day delay in reporting her injury was as soon as practicable and constituted timely notice under the Section 6(c) of the Act.

With regard to the Petitioner's failure to seek treatment until 13 days after her October 24, 2012 work injury, the Commission finds that Petitioner should not be penalized for her continued attempt to work through progressive pain until if affected her ability to work and required medical treatment. Durand v. Industrial Commission, 224 Ill.2d 53(2006). "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." Three "D" Discount Store v. Industrial Commission, 198 Ill. App. 3d 43, at 49(1989).

With regard to the issue of medical expenses under Section 8(a) of the Act, based upon finding of causal connection as stated above, the Commission awards $139,877.44 in related medical expenses, identified in PX1: $5,420.00 Orthopedic Center of Southern Illinois; $766.00 Dr. Paletta/Orthopedic Center of St. Louis; $5,311.00 Dr. Gornet/Orthopedic Center of St. Louis; $11,340.00 St. Louis Spine & Orthopedic Surgery Center; $2,300.00 MRI Partners of Chesterfield; $52,348.75 Dr. Raskas/Orthopedic & Sports Medicine; and $62,391.69 Missouri Baptist Medical Center.

Based upon the Commission's finding as to causal connection herein, and the supporting off work authorizations and testimony of the treating physicians, the Commission finds

Petitioner is entitled to temporary total disability benefits at the rate of $306.66 per week for a period of 84-3/7 weeks, from November 06, 2012 through June 19, 2014, that being the period of her temporary total incapacity for work under §8(b) of the Act. On November 06, 2012, Petitioner was authorized off work by Dr. Steinke. Thereafter she began treating with Dr. Gornet, and was continued off work from May 14, 2013 through May 09, 2013, at which time Dr. Gornet released her to return to work with significant work restrictions, which were not accommodated by Respondent. Dr. Raskas reiterated light duty work restrictions until her November 07, 2013 surgery, after which she was completely authorized off work. On May 20, 2014, Dr. Raskas authorized Petitioner to return to work with no lifting of more than 20 pounds, no repetitive bending, twisting or turning at the waist, and allowing for frequent change of position. Petitioner testified she has been unable to return to work through the date of hearing. (T26-27).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on September 02, 2014, is hereby modified for the reasons stated herein, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $306.66 per week for a period of 84-3/7 weeks, from November 06, 2012 through June 19, 2014, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $139,877.44 for medical expenses under §8(a) and pursuant to §8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: AUG 20 2015
KWL/kmt
O-06/23/15
42

Thomas J. Tyrrell

Michael J. Brennan

DISSENT

I respectfully dissent from the decision of the majority. I would affirm Arbitrator Lee's thorough and well-reasoned decision in its entirety and without modification.

Kevin W. Lamborn

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

15IWCC0642

HARVEY, DEBRA
Employee/Petitioner

Case# 12WC044496

12WC044630

DODDS CUSD #7
Employer/Respondent

On 9/2/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0969 THOMAS C RICH PC
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2674 BRADY CONNOLLY & MASUDA PC
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NORMAL, IL 61761

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

15IWCC0642

Debra Harvey
Employee/Petitioner

v.

Dodds CUSD #7
Employer/Respondent

Case # 12 WC 44496

Consolidated cases: 12 WC 44630

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 **Belleville**, on **6/19/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **10/24/12**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**23,920.00**; the average weekly wage was $**460.00**.

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

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

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

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

ORDER

THE ARBITRATOR FINDS PETITIONER HAS FAILED TO PROVE THAT HER CONDITION OF ILL BEING IS CAUSALLY RELATED TO THE ACCIDENT. ALL BENEFITS ARE DENIED.

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

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

Signature of Arbitrator

8/20/14
Date

SEP 2 - 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Debra Harvey, Petitioner, v. Dodds CUSD #7, Respondent.	))))))	15IWCC0642 No. 12 WC 44496

FINDINGS OF FACT

The petitioner works for Dodds CUSD #7 as a school cook. She has been employed in this role for approximately 15 years. She is responsible for preparing school meals and cleaning tasks associated with the same. She alleges an accident to her low back occurring on October 24, 2012. At that time, she was 51 years old.

October 24, 2012 Incident

The petitioner claims that on October 24, 2012 she assisted co-worker Debbie Rankin with lifting a table in the school cafeteria after lunch. She described the table as being on wheels with a hinge in the middle. To clear floor space the table lifts from a horizontal position to a vertical position at the middle hinge and the table is then rolled aside to clear space. She testified that she and Debbie Rankin stood at the hinge in the middle of the table on opposite sides and lifted. She estimated the total weight of the table to be approximately 100 pounds distributed evenly between the two women. She testified that the table began to fall and she had to move awkwardly with the table to keep it from falling. The petitioner testified that after the table was lifted she had immediate pain in her low back unlike any back pain she had ever experienced previously. She described immediate radiating symptoms down her right leg. She testified that the pain was very significant immediately. The petitioner testified that she continued working full duty until November 6, 2012.

Reporting the Accident

The date of accident was a Wednesday. The school was closed Thursday and Friday. The petitioner reported the injury for the first time on the following Monday. The petitioner testified that she was unable to immediately report the accident on the date of accident because school superintendent Craig Clark was unavailable. She testified that other individuals such as the school nurse were aware of her injury, but no witnesses were available at trial to testify on behalf of the petitioner concerning her reporting of the injury.

Testimony of Debbie Rankin

Debbie Rankin testified on behalf of the respondent. She is the school custodian. She was present with the petitioner on the date of accident. She assisted the petitioner with lifting the table. She does not dispute that the petitioner helped with lifting the table.

Ms. Rankin testified that she did not recall the table falling or that the petitioner moved awkwardly to stop the table from falling. Ms. Rankin did not observe any pain behavior from the petitioner during or after the alleged accident. Ms. Rankin testified that after the table lifting incident, the petitioner resumed her normal work duties free from pain for the remainder of the day.

Testimony of Craig Clark

Craig Clark testified on behalf of the respondent. He is the school superintendent. He testified that procedures in place at the school require an injured worker to report an accident immediately. Mr. Clark confirmed that the petitioner did not report the work accident until the following Monday. The petitioner knew how to report work accidents as she reported a prior accident immediately when it occurred on October 26, 2010.

Medical Treatment

The petitioner first sought medical care following the October 24, 2012 date of accident on November 6, 2012 at the Orthopedic Center of Southern Illinois with orthopedic spine

surgeon Dr. Bryan Steinke. (Rx3). This first treatment is two weeks after the date of accident. She described lifting a table, but made no mention of the table falling. She complained of diffuse back pain from her thoracic spine to her lumbar spine. She was diagnosed with a thoracolumbar muscle strain and degenerative changes from L2-S1. She was given pain medications and muscle relaxants. She was excused from work for one week.

The petitioner did not make significant improvements with conservative measures. On December 20, 2012, MRIs were performed of her lumbar spine and thoracic spine as ordered by Dr. Steinke. (Id.). The lumbar spine showed no disc protrusion, spinal stenosis or cord or nerve impingement. It did show minimal left foraminal stenosis at L2-3 and minimal right foraminal stenosis at L3-4 with no nerve root impingement and a very small disc extrusion at L5-S1 accompanied by a small tear within the posterior peripheral of the annulus.

The thoracic spine MRI showed a small central disc extrusion at T6-7, a small central disc extrusion at T7-8. (Id.). A small left paracentral disc extrusion at T9-10 and a small left paracentral disc protrusion at T10-11.

Following the MRIs, the petitioner followed up with Dr. Steinke on December 27, 2010. (Id.). He interpreted the MRIs as showing diffuse degenerative changes from the lower thoracic spine through the lumbar spine. He recommended physical therapy and continued off work status. The petitioner participated in physical therapy from January 9, 2013 through January 24, 2013.

The petitioner returned to Dr. Steinke on January 28, 2013. (Id.). She still complained of back pain to her mid and low back with some radiating symptoms into her right thigh and leg. Dr. Steinke felt that the petitioner was not a surgical candidate because he felt surgery would not benefit the petitioner. He referred her to a pain management physician for evaluation of possible injections. She remained off work. The petitioner never followed up again with Dr. Steinke. The

petitioner testified that this is because Dr. Steinke moved out of the area. She testified that she did not want to stay with the Orthopedic Center of Southern Illinois because colleagues at her workplace knew individuals that worked for that practice and she thought it would be in her best interest to treat elsewhere.

On January 2, 2013, the petitioner was examined by orthopedic surgeon Dr. George Paletta at the Orthopedic Center of St. Louis based on a referral from petitioner's attorney. (Px6). Dr. Paletta evaluated the petitioner's complaints of right lower extremity pain. The petitioner attributed these complaints to the lifting incident of October 24, 2012. Dr. Paletta performed an x-ray of the petitioner's right knee which was normal. Dr. Paletta believed the petitioner's right lower extremity complaints related to her back and so he referred the petitioner to his colleague, orthopedic spine surgeon Dr. Matthew Gornet.

The petitioner began treating with Dr. Gornet on January 15, 2013. (Px7). He reviewed the petitioner's MRI from December 20, 2012. Dr. Gornet asked the petitioner to obtain a copy of the previous MRI study performed on March 27, 2012.

The petitioner returned to Dr. Gornet on February 7, 2013. (Id.). He compared her March 2012 MRI against the December 12, 2013. Dr. Gornet interpreted the MRIs as showing an increased foraminal herniation on the right at L3-4. Dr. Gornet recommended a series of steroid injections at L5-S1 and L3-4. The injections were performed on February 15, 2013 and March 1, 2013. The petitioner did not make any significant improvement. Dr. Gornet recommended an updated MRI which was performed on May 9, 2013. (Px9). The MRI showed a broad-based disc protrusion/herniation from L2-3 to L5-S1 associated with a foraminal encroachment at L4-5. Dr. Gornet recommended a L3-4 fusion for the petitioner. (Px7). He diagnosed the petitioner with a disk herniation, which he opined was related to the work accident.

Dr. Frank Petkovich examined the petitioner pursuant to Section 12 on February 22, 2013. (Rx4). He is a board certified orthopedic spine surgeon. He diagnosed the petitioner with a thoracic strain, a lumbar strain and a temporary exacerbation of degenerative lumbar disc at L5-S1. He attributed these conditions to the October 24, 2012 accident. He recommended physical therapy and lumbar epidural injections at L5-S1. He recommended light duty restrictions for the petitioner. He found she was not at MMI at the time of the February 22, 2013 exam.

An addendum report was obtained from Dr. Petkovich on March 13, 2013. (Rx5). At that time, Dr. Petkovich was provided with pre-existing medical records documenting a history of low back pain and radiating pain into the petitioner's right lower extremity back to 2005. Dr. Petkovich noted that the additional records were inconsistent with the history he had been provided by the petitioner. However, his diagnosis and treatment recommendations did not change.

On June 12, 2013, Dr. Petkovich re-examined the petitioner. (Rx6). He believed at that point the petitioner's temporary strains had resolved and that her continued complaints were related to a pre-existing degenerative condition at L3-4. He did not recommend any further treatment for the October 24, 2012 work accident. He found the petitioner to be at MMI for the October 24, 2012 work accident. Dr. Petkovich's deposition was taken on September 23, 2013. (Rx10).

Dr. Gornet did not accept the petitioner's husband's group health insurance plan, so the petitioner began treating with orthopedic spine surgeon Dr. David Raskas beginning October 21, 2013. (Px10). The initial treatment record from Dr. Raskas was addressed to petitioner's attorney. Dr. Raskas recommended a lumbar fusion at L3-4. Surgery was performed on November 7, 2013. (Px11). The petitioner testified that she has had significant relief from the

surgery. She is still under active treatment and has a follow-up visit scheduled for November 2014. She remains off work per Dr. Raskas.

Subsequent to the petitioner's November 7, 2013 surgery, the respondent obtained records reviews from orthopedic spine surgeon Dr. David Lange on December 8, 2013, December 18, 2013 and February 5, 2014. (Rx 7, 8, 9). Dr. Lange reviewed all of the petitioner's pre-existing and post-date of accident medical records and MRI films and reports. He agreed with Dr. Petkovich's diagnosis of the petitioner. He did not find that the petitioner's work accident caused a new injury or aggravated any pre-existing condition. His deposition was taken on June 10, 2014. (Rx11).

CONCLUSIONS OF LAW

F. Whether petitioner's present condition of ill-being is causally related to the accident?

The Arbitrator finds that the petitioner's present condition of ill-being is not causally connected to the October 24, 2012 work accident. The decision is based in part on the petitioner's credibility. The Arbitrator finds the petitioner is not credible. The petitioner testified that she had immediate severe pain with radiculopathy following the lifting incident, but the evidence does not support this assertion. The date of accident occurred on a Wednesday. The petitioner did not report the injury until the following Monday. The petitioner also did not seek any medical treatment until two weeks after the accident (Rx3) during which time she worked full duty. These facts are inconsistent with her complaints of immediate and significant pain and symptoms.

The Arbitrator also notes that the petitioner's description of the accident changes throughout the medical records. Initially, the petitioner stated that she was injured lifting a table. (Rx3, Rx4). However, over time the records evolved to reflect that while she was lifting the table it began to fall and she awkwardly moved herself with the falling table. (Px 6, 7, 10).

Respondent's witness Debbie Rankin testified that at no point did the table fall and she did not observe any awkward movements by the petitioner. These inconsistencies in the petitioner's testimony bear negatively on her credibility.

While the petitioner conceded a prior history of back pain before the October 24, 2012 date of accident, the petitioner testified that the pain she experienced post-accident was unlike any previous back pain. She testified that post-accident she had low back pain radiating down her right leg. This testimony is contradicted by the medical records. Specifically, the petitioner's pre-existing medical history reflects the following (Rx2):

Date	Treater	Complaint
12/13/05	Dr. Jose Amorado/PCP	degenerative disc disease, L-spine x-ray taken
9/21/06	Dr. Amorado	Scoliosis, ddd, radiating pain to right buttocks
7/3/07	Dr. Amorado	Back ache
5/21/10	Dr. Amorado	right lower back pain, radiates to right buttocks/thigh. MD recommends injections and MRI
9/23/11	Dr. Amorado	lumbar radiculopathy
3/27/12	MRI l-spine	multilevel degenerative changes and disc narrowing and protrusions including L3-4

The Arbitrator notes the petitioner's pre and post-date of accident complaints are similar.

It is very pertinent to note that the petitioner was under active orthopedic care for complaints of low back pain with her primary care physician Dr. Amorado in the days before the October 24, 2012 work accident. Specifically, Respondent's Exhibit 2 shows:

Date of Service	Record shows
10/4/12	Referral was made to rheumatologist Dr. Frederick Pfalzgraf for evaluation and treatment of degenerative disk disease and a MRI
10/6/12	Dr. Pfalzgraf responds that he is not accepting patients with low back pain and/or degenerative disk disease
10/9/12	A referral is made again to Dr. Pfalzgraf for arthritis and joint pain
10/8/12	Dr. Pfalzgraf responds again that he is not accepting patients with low back pain and/or degenerative disk disease
10/18/12	Follow up for back ache
10/23/12	A referral was made to orthopedic spine surgeon Dr. Brian Steinke for evaluation and treatment of a backache.

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)
Decision Vacated and Remanded	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

KEVIN MORAN,

Petitioner,

15IWCC0643

vs.

NO: 11 WC 39112

CITY OF CHICAGO,

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues nature and extent, and whether Arbitrator Williams improperly issued a Decision in this matter, and being advised of the facts and law, vacates Arbitrator Williams's Decision, and remands this matter back to the Arbitration level and orders that Arbitrator Nowak, whom conducted the hearing in this matter, issue a Decision based upon the evidence presented at the time of the hearing held before him on September 29, 2014.

This matter was tried to completion on September 29, 2014, before Arbitrator Nowak in Chicago. The Petitioner testified at that time and proofs were closed. Prior to issuing a decision in this matter, Arbitrator Nowak was transferred to a new venue, and the matter was reassigned to Arbitrator Williams. Based on his reading of the transcript, Arbitrator Williams issued this October 14, 2014 Decision, without stipulation of the parties. Nothing in the Act or Rules permits one Arbitrator to issue the decision of another Arbitrator, without stipulation of the parties. The Commission finds that Arbitrator Williams lacked jurisdiction to issue the decision in this matter.

15IWCC0643

Accordingly, the Commission vacates Arbitrator William's October 14, 2014 Decision, and remands the matter back to Arbitrator Nowak for purpose of issuing a Decision in this matter based upon the arbitration hearing he conducted on September 29, 2014.

This decision is interlocutory and thus not appealable.

IT IS THEREFORE ORDERED BY THE COMMISSION that the October 14, 2014 Decision of Arbitrator Williams is hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this matter is remanded to Arbitrator Nowak for purpose of issuing a Decision in this matter consistent with the Commission's Decision.

DATED: AUG 20 2015
KWL/kmt
O-08/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION

NOTICE OF ARBITRATOR DECISION

15IWCC0643

MORAN, KEVIN
Employee/Petitioner

Case# **11WC039112**

CITY OF CHICAGO
Employer/Respondent

On 10/14/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0391 HEALY SCANLON
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CHICAGO, IL 60602

0113 CITY OF CHICAGO LAW DEPT
STEPHANIE LIPMAN
30 N LASALLE ST SUITE800
CHICAGO, IL 60602

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

15IWCC0643

KEVIN MORAN
Employee/Petitioner

Case #11 WC 39112

v.

CITY OF CHICAGO
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 an arbitrator of the Workers' Compensation Commission, in the city of Chicago, on September 29, 2014. After reviewing all of the evidence presented, the Honorable Robert Williams hereby makes findings on the disputed issues and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☐ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☐ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On May 3, 2011, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- On this date, the petitioner sustained injuries that arose out of and in the course of employment.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $73,216.00; the average weekly wage was $1,408.00.
- At the time of injury, the petitioner was 56 years of age, married with no children under 18.
- The petitioner agreed that the respondent paid the appropriate amount for all the related, reasonable and necessary medical services provided to the petitioner.
- The parties agreed that the respondent would pay the $290.00 bill of Northwestern Orthopaedics and Sports Medicine pursuant to the fee schedule.
- The parties agreed that the respondent paid $80,192.67 for temporary total disability and maintenance benefits.
- The parties agreed that the petitioner is entitled to temporary total disability benefits for 57-5/7 weeks, from May 9, 2011, through June 15, 2012, and maintenance benefits for 27-2/7 weeks from June 16, 2012, through July 31, 2012, and from December 4, 2012, through April 30, 2013.

ORDER:

- The respondent shall pay the petitioner the sum of $669.64/week for a further period of 100 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person for his left shoulder injury.

- The respondent shall pay the petitioner compensation that has accrued from May 3, 2011, through September 29, 2014, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Robert E. Williams

Signature of Arbitrator

October 10, 2014

Date

OCT 14 2014

FINDINGS OF FACTS:

The petitioner, a right-handed heavy-duty laborer with the respondent's water department, sustained a left shoulder injury on May 3, 2011, after falling off a ladder. He began care at MercyWorks on May 6th and reported left shoulder pain and difficulty lifting his arm over his head. He was given medication and work restrictions for a left shoulder contusion. He received physical therapy from May 12th through June 6th. An MRI on June 14th revealed a large effusion at the glenohumeral joint, thickening of the distal portion of the supraspinatus tendon with a subtotal tear at its articular surface.

Dr. Christopher Mahr saw the petitioner on June 17th and noted a positive impingement sign. He opined that the MRI revealed a large full-thickness supraspinatus tendon tear. On July 6th, the petitioner had a left shoulder arthroscopic rotator cuff repair, debridement and a subacromial decompression by Dr. Mahr. Due to the petitioner's age, Dr. Mahr did not repair a degenerative anterior and posterior labral tear discovered during surgery. The petitioner retuned to restricted work on April 16, 2013, and continued following up with Dr. Mahr periodically through April 23, 2014. Dr. Mahr noted no pain complaints at the last follow-up and released the petitioner to full duties beginning May 1st. The petitioner had a full range in his shoulder motion and a 5/5 rotator cuff muscle strength in all the major muscle groups.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner complains of left arm pain, weakness, loss of function and sensitivity to temperature changes and dampness. The respondent shall pay the petitioner the sum of $669.64/week for a further period of 100 weeks, as provided in Section 8(d)2

of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 20% loss of use of the person for his left shoulder injury.

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 WINNEBAGO	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Carol Harris,
Petitioner,
vs.

NO: 11WC 39915

15IWCC0644

Chrysler, LLC.,
Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 7, 2014, is hereby affirmed and adopted.

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

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

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

DATED: AUG 21 2015
o081215
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARRIS, CAROL
Employee/Petitioner

Case# 11WC039915

CHRYSLER LLC
Employer/Respondent

15IWCC0644

On 10/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0293 KATZ FRIEDMAN EAGLE ET AL
DAVID M BARISH
77 W WASHINGTON ST 20TH FL
CHICAGO, IL 60602

WIEDNER & McAULIFFE LTD
LLOYD McCUMBER
1639 N ALPINE RD
ROCKFORD, IL 61107

STATE OF ILLINOIS)
)SS.
COUNTY OF **Winnebago**)

☐ 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

Carol Harris
Employee/Petitioner
v.
Chrysler, LLC
Employer/Respondent

Case # **11** WC **39915**

15IWCC0644

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas Holland**, Arbitrator of the Commission, in the city of **Rockford**, on **September 24, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **August 27, 2010**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did not* sustain an accident that arose out of and in the course of employment.

In the year preceding the injury, Petitioner earned $**30,534.40**; the average weekly wage was $**587.20**.

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

ORDER

No benefits are awarded because the Petitioner failed to prove that she sustained an accident arising out of her employment.

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.

Milton Black

Signature of Arbitrator

October 7, 2014

Date

OCT 7 - 2014

Statement of Facts

Petitioner testified that on August 27, 2010, she was employed by Respondent as an assembler. She testified that she began working for Respondent in May, 2006. She testified that she had been performing the same jobs between 2006 and 2010. She testified that she was in Department 9171 which placed tires on the vehicles. She testified that she performed six functions, three on each side of the vehicle. Petitioner testified that she was left handed and used her left hand on the tools.

She testified that the first function was to place the tires on the vehicle and put two lug nuts on. She testified that she would tighten the nuts with an air gun. She testified that she used her left hand to operate the air gun and testified that the air gun would be jerky, had a kick and would jerk her hand. She testified that she would work on 65 cars per hour. She testified that the second job was to put on three more lug nuts on the front and rear tires and a plug for the fuel tank. She testified that the third job was to use a barrel gun to tighten the lug nuts.

She testified that her finger started hurting in June, 2010. She testified that she noticed it when she had to hold the gun up.

She first saw Dr. Woodman, her personal doctor. The doctor's records (Petitioner's Exhibit 1) reflect that she was scheduled for x-rays of the left index finger on June 29, 2010. The X-ray report note "Pain for 3 days."

There is mild osteoarthritic change noted. Dr. Woodman's June 30 note states "old injury v. osteomyelitis." On July 17, 2010, Dr. Woodman's history is pain in her left index finger and has difficulty working with it. He referred her to Orthopedics.

Petitioner was seen by Dr. Edric Schwartz at Rockford Orthopedic Associates on August 27, 2010. Records were offered into evidence as Petitioner's Exhibit 2 and Respondent's Exhibit 3. The August 26, 2010 telephone encounter records a history of left hand pain due to injury. Patient had pain after working in the yard (06/2010). This same history is recorded by Dr. Schwartz in his August 27, 2010 office note. The diagnosis at that time was osteoarthritis of the left hand. Dr. Schwartz performed an injection into the MCP joint of the left index finger. Petitioner returned to Dr. Schwartz on October 1, 2010 with continued pain over the mass on her index finger.

She testified she proceeded with surgery October 18, 2010 for removal of bony material from the area on her finger. She missed a couple of days of work and went back. She testified that she felt better but that as 2010 turned to 2011, it started hurting again.

Dr. Schwartz records reflect post operative visits on November 3, 2010 and December 8, 2010 with improvement in pain but continued problem with fine motor skills. Petitioner continued to treat with Dr. Schwartz with increasing complaints and underwent replacement of the metacarpal phalangeal joint on September 26, 2011. Petitioner was off work through 12/14/11. Petitioner testified that she has returned to her regular job.

Petitioner testified that she told her supervisor Steve Leathers that she injured her hand and finger working in the yard after seeing Dr. Schwartz. She testified she did not hurt her hand in the yard, but told the doctor and her supervisor that story because she didn't want to create trouble at work. She testified that she didn't want to get moved or end up getting terminated. She testified that after the surgical recommendation she spoke again with Steve Leathers when he came by her work station. She testified that she stopped him to let him know that the doctor requested surgery and that it really didn't happen in the yard, it happened at work. She testified that he only responded by asking if she was okay to do the job that night.

Steve Leathers testified that in 2010 he was the supervisor of Group 12 and was Petitioner's supervisor. He did not recall Petitioner reporting any problem to her left hand to him in August, 2010. He denied that she told him of a work related problem to her left hand in October, 2010. He testified that any injury, work-related or not required a statement to be filled out. He testified that the procedure then required the employee to go to medical.

Petitioner testified that she was aware of the reporting procedures. She testified that she filled out a Workers' Compensation work related incident form for a different body part in December, 2010.

The records from plant medical were entered into evidence as Respondent's Exhibit 1. The records record other reported incidents from Petitioner, both work related and non work related before the date of the claimed accident.

Dr. Schwartz deposition was offered as Petitioner's Exhibit 3. Dr. Schwartz testified to his treatment as outlined in his records. His diagnosis was ostoearthritis. Dr. Schwartz opined that the osteoarthritis would be a culmination of repetitive trauma. Dr. Schwartz opined that the work activities would not cause the osteoarthritis. Dr. Schwartz opined that repetitive use would definitely aggravate the osteoarthritis. Dr. Schwartz opined that the job could aggravate the condition but would not have caused it. Dr. Schwartz testified that he did not have a

history of a work injury. Dr. Schwartz testified that the best evidence of what brought on the symptoms is the history in his records and that history was of working in her yard.

Petitioner testified that she returned to work towards the end of 2011. She last saw Dr. Schwartz for a recheck in May, 2012. Petitioner testified that she has ongoing symptoms.

Conclusions of Law

With respect to C (Accident), the Arbitrator finds as follows:

Petitioner seeks recovery on a theory of repetitive trauma. Petitioner testified that she noticed pain while performing her job duties using the air gun. However, her testimony is not corroborated by the medical records. The medical records contain no history of a work related injury or detail of petitioner's claim of an injury from her work activity even after the date she testified she "corrected" her history to her supervisor. The history relates her injury to working in her yard in June, 2010.

Furthermore, her testimony is contradicted by her supervisor Steve Leathers. Her explanation for giving the non-work related history, that she was concerned about her job, is unpersuasive in light of her reporting other injuries both before and after the alleged date of manifestation.

Based upon the totality of the evidence, the Arbitrator finds that the Petitioner has failed to prove by the preponderance of the credible evidence that she sustained accidental injuries arising out of her employment with Respondent.

In light of the Arbitrator's findings on accident above, the remaining issues are moot.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antonyo Isby,
Petitioner,

vs.

NO: 11WC 27812

AT&T,
Respondent,

15IWCC0645

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 accident and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 22, 2014, is hereby affirmed and adopted.

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

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

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

DATED: AUG 21 2015
o081215
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

ISBY, ANTONYO
Employee/Petitioner

Case# **11WC027812**

AT&T
Employer/Respondent

15IWCC0645

On 10/22/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4239 THE LAW OFFICES OF JOHN S ELIASIK
180 N LASALLE ST
SUITE 3700
CHICAGO, IL 60601

0766 HENNESSY & ROACH PC
LAUREN SERAFIN
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

15IWCC0645

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Antonyo Isby
Employee/Petitioner

v.

AT&T
Employer/Respondent

Case # 11 WC 27812

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **7/22/2014, 8/18/2014 and 8/22/2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0645

FINDINGS

On the date of accident, **5/19/2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**61,624.68**; the average weekly wage was $**1,185.09**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Petitioner has not proven, by a preponderance of the evidence, that an accident occurred, which arose out of and in the course of his employment by Respondent, therefore no benefits are awarded, pursuant to the Act.

Respondent shall be given a credit for any bills paid by its group insurance company pursuant to Section 8(j) of the Act.

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

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

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

15IWCC0645

FINDINGS OF FACT

The disputed issues in this matter are: 1) accident; 2) notice; 3) causal connection; 4) temporary total disability; 5) penalties; 6) attorney's fees; 7) medical bills; and whether the petitioner is entitled to prospective medical treatment. *See,* AX1.

Petitioner's Testimony

The petitioner testified that he has worked for Respondent, AT&T, for approximately seven to eight years. Initially, he worked as a cable technician for two years. After a lay-off, he returned to work for Respondent as an advanced solutions technician, for four to five years. He testified that most recently, his title changed to infrastructure maintenance technician for approximately one year before the alleged work injury. The petitioner further testified that as an infrastructure maintenance technician and he climbs ladders, goes into terminals, makes connections and does "premise work." He also testified that the company vehicle he drives, as an infrastructure maintenance technician, is different from the van used as an advanced solutions technician, as it is higher off the ground.

The petitioner had a previous injury to his lower back in 2008 or 2009. He stated he was off work for a period of three years for that injury. He testified that after that injury, he worked continuously from August or September of 2010 through the date of the subject alleged work accident. The petitioner denied that he never had any neck, left shoulder or left hand pain of any kind, prior to May 19, 2011. Tr. 7/22/14; pgs.12-18.

Petitioner presented to Dr. Malek for treatment for his prior work injury. Dr. Malek prescribed a course of physical therapy and chiropractic care at Taylor-Ogden Medical Center, which Petitioner testified provided minimal relief. PX2.

The petitioner testified that on May 19, 2011, he presented to work at 8:00 a.m., as an infrastructure maintenance technician. After his third job of the day, while retrieving a work ladder from the top of the company van, he "heard a pop" and felt sharp pain in his left shoulder. He testified that he felt okay and continued to work. At the end of the day, he returned his work vehicle to the company garage and went home. He testified he did not report his injury on this day. Tr. 7/22/14; pgs. 20-23.

The petitioner testified that the next day, he went to work and after attendance was taken, he reported his injury to Ms. Helen Saxon. He testified that he never filled out a work injury report, that he was not offered an opportunity to visit Concentra Medical Center ("Concentra"), a clinic that treats injured AT&T workers. Although he testified that he was aware that the respondent sends injured workers to this clinic, he did not request to see the doctors at Concentra; instead, he worked without seeking medical treatment until May 25, 2011. Tr. 7/22/14; pgs. 24-25.

On May 25, 2011, the petitioner treated with Dr. George Bridgeforth, at Concentra. Petitioner testified that on the first visit, he told Dr. Bridgeforth of the lifting incident with the ladder, however, the history in Dr. Bridgeforth's records, does not reflect such an incident. PX1.

The records indicate that the patient was a 34-year-old male employee of AT&T, complaining about his back, which was injured on November 18, 2009. The Arbitrator notes that the Petitioner testified that he had not presented to Concentra, for his prior injury, for five or six months.

Dr. Bridgeforth indicated that Petitioner reported his problem as low back pain, and noted that Petitioner complained of pain on the left side of his neck and "thickness" in his palm. Dr. Bridgeforth states that Petitioner did not have any significant findings related to his injury for the low back, and that he had a new complaint of soreness in the neck within the last three weeks; which Petitioner stated was a result of working. Dr. Bridgeforth recommended a cervical MRI. PX1.

Petitioner returned to Concentra on June 1, 2011. Petitioner was complaining of moderate cervical soreness, and he was not able to turn his head. He also reported ongoing low back pain from his prior injury. Dr. Bridgeforth indicated that Petitioner was being seen for a "cervical strain, rule out disc herniation". Dr. Bridgeforth did a cervical x-ray, which showed decreased cervical lordosis, and ordered a cervical MRI to rule out a disc injury. Dr. Bridgeforth also noted that Petitioner demonstrated good function for his lower back. Petitioner was released with light duty restrictions.

Petitioner returned to see Dr. Bridgeforth on June 8, 2011. The cervical MRI had not been done. Dr. Bridgeforth continued Petitioner with light duty restrictions, and continued to recommend a cervical MRI. Petitioner started a course of physical therapy at Taylor-Ogden Medical Center on June 11, 2012, which went through August 18, 2011. Petitioner testified that he did not get any relief. Respondent still did not approve the recommended MRI. PX3.

Petitioner returned to Dr. Malek on June 16, 2011. Petitioner reported that he was doing well until May 19, 2011, when he was injured at work again. Petitioner reported that on that date, he was lifting a ladder off his truck when he felt pain in the neck radiating into the left shoulder with tingling and numbness down the left upper extremity, especially the index and middle finger. Petitioner indicated reporting the injury to his supervisor on May 25, 2011. Dr. Malek recommended medication, physical therapy for four (4) weeks and a cervical MRI. He also returned Petitioner to work with light duty restrictions. PX2.

Petitioner returned to work November 3, 2011 and he testified that Respondent had him working in a full duty capacity. Petitioner did not receive any additional medical treatment until he returned to see Dr. Bridgeforth on January 11, 2012, at the request of Respondent. At this time, Petitioner's chief complaint was cervical pain, which was moderate to severe along the left side of his neck and numbness in the left arm. Dr. Bridgeforth indicated that Petitioner reported having a cervical MRI

that showed three (3) cervical herniated discs from his prior injury, but that he did not require surgery. This appears to be an error, as Petitioner injured his lower back in the prior injury, and had not yet had a cervical MRI. Dr. Bridgeforth diagnosed Petitioner with chronic cervical radiculopathy, and recommended a cervical MRI, a left shoulder MRI and an EMG. He was returned to work with light duty restrictions. PX1.

The petitioner testified that after his condition did not improve, he underwent two injections from Dr. Malek, which provided relief. Ultimately, Dr. Malek recommended surgery, which the petitioner testified he would like to undergo. The petitioner testified that he was truthful with the information he provided Dr. Malek and the physicians at Concentra.

Petitioner testified that Respondent did not accommodate Dr. Bridgeforth's restrictions or authorize the MRI and Petitioner did not return to work, his last day being February 3, 2011.

On March 1, 2012, Petitioner returned to Dr. Malek who continues to recommend a cervical MRI. Petitioner testified that Dr. Malek told him there was nothing more he could do without the MRI. PX2.

Petitioner had an EMG test on August 7, 2013, which was read to indicate mild left carpal tunnel syndrome, and moderate, chronic C5-6 and C6-7 left-sided radiculopathy. PX13.

Testimony of Helen Saxon

Respondent called Ms. Helen Saxon as a witness. Ms. Saxon testified that she has worked for Respondent since 1971. She retired in December of 2013, and at the time of her retirement, she was Petitioner's supervisor. She testified that as a supervisor, all employees were trained, on a monthly basis, how to report workplace accidents and the procedures for reporting any injuries in the workplace. Tr. 7/22/14; pgs. 55-57.

Ms. Saxon further testified that she has known the petitioner since approximately 2008 and that she was aware of his previous work injury in 2009. Although she was not his supervisor, she was aware that he had properly reported that injury to his supervisor. She testified that she became his supervisor around the beginning of 2011, but could not be certain because at that time, he was off work for the previous 2009 injury. Ms. Saxon testified that when he returned to work from the 2009 injury on April 1, 2011, he presented to work with a suspended driver's license. As driving a vehicle was part of his job duties, he was unable to work and it was recommended that he take vacation days until this issue was resolved. Tr. 7/22/14; pg. 64.

Ms. Saxon testified that when he returned to work on April 12, 2011, Petitioner was complaining of pain from the 2009 motor vehicle accident, i.e. neck and hand pain, which was preventing him from working in a full duty capacity. Ms. Saxon and her supervisor arranged a meeting with the petitioner

to discuss how to handle his complaints. Due to a failure to provide medical documentation that corresponded with his complaints, and in order to allow him time to resolve his health issues, he was given a leave of absence. Ms. Saxon testified that the meeting in April was the only meeting she had with the petitioner to discuss his complaints. Tr. 7/22/14; pgs. 68-105.

Ms. Saxon testified that the petitioner returned to work on May 10, 2011 and that he never discussed any injury with her. As no injury was reported to her, no documentation of an injury was prepared. Ms. Saxon testified that she was not made aware of an allegation of a work injury until August 9, 2011, when someone from Sedgwick, in the Workers' Compensation Department, contacted her. Ms. Saxon also testified that when the Sedgwick employee contacted her, on August 9, 2011, she denied being aware of an injury to Petitioner. Ms. Saxon testified that the only reports of pain Petitioner made to her occurred prior to the subject date of injury; when he returned from his 2009 work injury, and complained of residual neck and hand discomfort. According to Ms. Saxon, this reporting of pain took place in April 2011. Tr. 7/22/14; pg. 59.

Ms. Saxon further testified that she was certain that the petitioner never reported an injury to her and that the petitioner had complained of neck pain in the meeting for his leave of absence in April, prior to May 19, 2011. She testified that no conversations with the petitioner about any pain or discomfort occurred after May 19, 2011. Tr. 7/22/14; pg. 77.

Petitioner's Rebuttal Testimony

The petitioner testified that he took periods of administrative leave prior to his alleged work accident of May 19, 2011. He testified that he returned to work from his 2009 motor vehicle accident in August 2010 and entered training. Afterwards, he was placed on administrative leave because his driver's license was suspended. He further testified that on April 14, 2011, he took a second administrative leave due to unrelated personal issues. The petitioner also referenced a personal car accident that occurred around this time. He stated that a few months passed between his period of personal leave in April 2011, and the alleged work injury. The petitioner further testified that Ms. Saxon's testimony that he had only worked a few days between his administrative leave and the alleged work injury, was incorrect. After this testimony, Petitioner's attorney requested to amend the Request for Hearing to indicate an accident date of May 18, 2011. Respondent objected and was instructed to address his objections in his proposed findings.

Medical Treatment

The petitioner initially presented to Concentra on May 25, 2011 after the alleged work accident date. On that date, under "Patient Statement," it was noted that the petitioner stated: "I was involved in a car accident in 2009 and I am still feeling pain in my neck and back." The injury date was listed as November 18, 2009. The petitioner's previous November 18, 2009 work accident was noted, and he remarked that his employer had discontinued his therapy, which left him angry and frustrated. The petitioner noted that he could not relate any specific instance that triggered an abrupt pain response.

Under the "Assessment" portion of the treatment note, Dr. Bridgeforth stated that the petitioner alleged pain in his neck, which was three weeks old, but that he could not ascribe any particular instance at work, which produced the acute pain. RX1.

On June 1, 2011, Petitioner returned to Concentra complaining of back pain since 2009. He alleged neck pain for the past three weeks. On June 8, 2011, the petitioner presented to Concentra, complaining of neck and chronic low back pain. The date of accident was listed as November 18, 2009. He returned to Concentra January 11, 2012, complaining of persistent pain in his neck and low back since a motor vehicle accident in 2009. No additional complaints of specific instances of an accident were noted.

On June 16, 2011, the petitioner presented to Dr. Malek complaining of a work accident occurring on May 19, 2011. The petitioner reported to Dr. Malek that on May 19, 2011 at 11:00 a.m., he was taking a ladder weighing about one hundred (100) pounds off his truck, and felt immediate pain in his neck. The note also indicated that he reported his injury to his supervisor on May 25, 2011. Dr. Malek continues to treat the petitioner and the doctor currently maintains a diagnosis of cervical radiculopathy. Dr. Malek has recommended cervical injections and if no improvement is reported, cervical fusion surgery. Rx2.

Deposition of Dr. Kern Singh dated July 2, 2014

By request of Respondent, the petitioner underwent an independent medical evaluation ("IME") with Dr. Singh. After examination of Petitioner and taking a history of the mechanism of injury, Dr. Singh provided the petitioner with a provisional diagnosis of a cervical muscular strain. During his deposition, Dr. Singh testified that he believed the petitioner had a cervical strain and needed an MRI. An MRI was performed on September 12, 2012, which was read to show a large herniation at C6-C7. The doctor further testified that the petitioner would benefit from an epidural injection and if it was still symptomatic, a fusion at that level. PX10 pgs. 3-12.

He further testified that that the need for this treatment was causally related to the lifting accident that the Petitioner related to him but that his opinions on causation were based upon the assumption that a work injury occurred. Dr. Singh testified that in the event additional information was evident that there was no work injury, his opinions on causation would change. The Arbitrator notes that Petitioner put this doctor's deposition into evidence. PXs 10-12.

Attendance Report

The petitioner's attendance report was included as Respondent's exhibit 10. The attendance report documents the periods that the petitioner was off work in 2011. Prior to his alleged work accident, he was off work consistently through April 11, 2011, either on vacation days or unpaid absences. On the second to last page of the exhibit, the petitioner was noted to have taken a personal leave of absence

15IWCC0645

on April 18, 2011 and returned to work May 10, 2011. The petitioner was also off work May 19, 2011 and May 20, 2011 for vacation, and then was on unpaid absences beginning May 25, 2011. RX5.

Social Media

Respondent entered into evidence a Facebook page for "Ali Is." Ali Is listed the petitioner as being the President of "Xtreme Visual Concepts," Founder of "Isbyn 1 Enterprise," and Production and Editing Executive at "Vibe's Soul Poetry Café." The petitioner denied that the Facebook page belonged to him, however, admitted he was aware of the profile and at one time, "shared" the profile with a man named "Cortez." The Facebook page promotes an audiovisual company in the photographs. The petitioner is photographed in various pages in the exhibit, including photographs taken of him in an AT&T uniform. RX7, pgs. 4-142.

Respondent also submitted into evidence Sedgwick Background Search reports. In Respondent's Exhibit 5, the Sedgwick Investigative Unit prepared a background check on the petitioner and retrieved his LinkedIn profile. He was identified as the "Owner, Sound Check Audio, High Definition Media Group and World Access Records Printing and Distributing." Sound Check Audio is also listed on the "Ali Is" Facebook page. Respondent's Exhibit 5 also depicts a photograph taken from the petitioner's Facebook page holding camera equipment overhead. The exhibit also included the Facebook page of Xtreme Visual Concepts website, listed as "being founded" in 2011.

CONCLUSIONS OF LAW

C. Did an accident occur that arose out of and occurred in the course of his employment with Respondent?

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).

The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v*

Industrial Commission, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).

It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986).

Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally*, *Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

An employee's unrebutted description of an alleged accident can be the basis for an award of benefits, provided the allegations are supported by the evidence presented. However, in this case, the petitioner's testimony, as to the history of accident, is rebutted by the individual to whom he testified he reported his injury. Further, his testimony is not supported by the medical records he submitted into evidence or his attendance report provided.

The Arbitrator finds Petitioner was not credible at trial based upon a series of inconsistent and incorrect statements made. The petitioner testified, under oath, that he worked consistently from August through the date of his alleged work accident, May 19, 2011. Petitioner's testimony as to his attendance is discredited by the testimony of Respondent's witness, Helen Saxon, and Petitioner's attendance record. Ms. Saxon testified that she became the petitioner's supervisor in January of 2011, but never worked with him because of his off-work status for his 2009 previous injury.

Ms. Saxon testified that it was not until April of 2011 that the petitioner returned to work. Due to an issue with his driver's license, he was not able to return to work immediately. When he did return to work, Ms. Saxon testified that he continued to complain of restrictions from his previous work injury in 2009, and took a leave of absence until that condition was resolved. Ms. Saxon testified that he returned to work in May 2011, he worked for a few days before leaving again, and did not make any complaints of a new work injury. Ms. Saxon's testimony is corroborated by the attendance report of the petitioner. .

The petitioner testified at trial that he worked consistently from August 2010 until May 2011, without any problems. After Ms. Saxon's testimony, the petitioner testified that he did take a leave of absence for his driver's license and 2009 work injury issues, but worked for at least a few months before the subject work injury. When asked if he had merely worked a few days before the alleged work injury, he testified "absolutely not." Petitioner's testimony is contradicted by the attendance report, as well as his own testimony. He testified he was off work for two to three years for a 2009 injury. However, he also testified he worked from August 2010 through May 2011, consistently. In order to be off work for two to three years after 2009, he would have had to be off work until 2011 or 2012. It is impossible for his testimony to be accurate or credible.

Further, the petitioner testified that he reported his work injury to Ms. Saxon the day after it occurred, either May 20, 2011 for a May 19, 2011 work injury, or May 19, 2011 for a May 18, 2011 work injury. The Arbitrator notes that the petitioner's testimony is contradicted by Helen Saxon, who testified that Petitioner did not report an injury to her. Further, the Arbitrator does not find Petitioner's history of injury to be credible for either date of accident because according to the attendance report, he was not at work to report his injury. According to Respondent's Exhibit number 10, the petitioner was off work on both May 19, 2011 and May 20, 2011. The Arbitrator finds Ms. Saxon's testimony more credible than that of the petitioner, as the evidence admitted at hearing corroborates her testimony.

The Arbitrator also finds Petitioner's testimony not credible based upon his denial of any prior injury to his neck. The petitioner denied recalling the contents of a prior settlement contract, despite the fact that he testified the contract was signed by him. On the terms of the settlement contract, a neck injury was listed. *Isby v. AT&T*, 10 WC 00991. Respondent also offered evidence from Loreto Hospital for the 2009 injury. Those records document an initial report of neck pain.

Lastly, Petitioner's testimony is discredited by his own medical records. The initial treatment visit, as well as subsequent visits with Concentra, documents that the petitioner was "frustrated" and "angry" because his treatment for his 2009 injury had been denied by Respondent. The treatment notes attribute his pain only to the 2009 work injury. The physician specifically asked the petitioner whether any specific injury happened, and the petitioner stated there was no specific incident.

The petitioner testified that he reported the new injury to the physicians at Concentra, but did not know why the physician did not report any of it in his treatment notes. The Arbitrator finds this explanation implausible. The petitioner testified that Concentra is the facility where all of AT&T employees present for work injuries, and therefore, the facility would be aware of the importance of documenting any history of injury occurring at work. This rationale is likely why the physician specifically asked the petitioner if any new injuries had occurred. In order for the petitioner's testimony to be accurate, not only would the medical facility have had to omit statements made by the petitioner, but it would also have had to falsify statements made by him that no injury occurred; on multiple office visits. The Arbitrator finds that the physicians would have no incentive to withhold this information in the treatment notes, especially on multiple visits.

Therefore, the Arbitrator finds and concludes that the petitioner has not proven, by a preponderance of the evidence that an accident occurred, which arose out of and in the course of Petitioner's employment with Respondent therefore, no benefits are awarded, pursuant to the Act. As the Petitioner has not proven that an accident occurred, the remaining issues are moot and will not be addressed.

15IWCC0645

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
11 WC 27812
SIGNATURE PAGE

Signature of Arbitrator

October 21, 2014
Date of Decision

OCT 22 2014

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

John Eric Thomas,
Petitioner,
vs.

NO: 10WC 15250

15IWCC0646

Prairie State Industries,
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, permanent partial disability, penalties, fees, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 5, 2014, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,000.00.The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 21 2015
o081115
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

THOMAS, JOHN ERIC
Employee/Petitioner

Case# **10WC015250**

PRAIRIE STALE INDUSTRIES
Employer/Respondent

15IWCC0646

On 8/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2512 THE ROMAKER LAW FIRM
PATRICK SEROWKA
211 W WACKER DR SUITE 1450
CHICAGO, IL 60606

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONACCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

15IWCC0646

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

John Eric Thomas,
Employee/Petitioner

v.

Prairie State Industries,
Employer/Respondent

Case # **10** WC **15250**

Consolidated cases: **none**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Peter M. O'Malley**, Arbitrator of the Commission, in the city of **Geneva**, on **4/21/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0646

FINDINGS

On **10/23/08**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being with respect to his right shoulder ***is*** causally related to the accident, but that Petitioner's current conditions of ill-being with respect to his neck/cervical spine as well as his right and left hands/wrists/fingers ***are not*** causally related to the accident.

In the year preceding the injury, Petitioner earned $**35,360.00**; the average weekly wage was $**680.00**.

On the date of accident, Petitioner was **23** years of age, ***single*** with **no** dependent children.

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

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

Respondent shall be given a credit of $**12,572.19** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $**12,572.19**. (See Arb.Ex.#1 & 2).

Respondent is entitled to a credit of $**0.00** under Section 8(j) of the Act. (See Arb.Ex.#1 & 2).

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $453.33 per week for 32-1/7 weeks, commencing 5/2/09 through 6/3/09 and from 12/2/11 through 6/10/12, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from October 24, 2008 through April 21, 2014, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall be given a credit of $12,572.19 for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $2,929.02, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $408.00 per week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in § 8(d)2 of the Act.

Respondent shall pay to Petitioner penalties of $**0.00**, as provided in Section 16 of the Act; $**0.00**, as provided in Section 19(k) of the Act; and $**0.00**, as provided in Section 19(l) of the Act.

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

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

Signature of Arbitrator

7/28/14
Date

AUG – 5 2014

15IWCC0646

STATEMENT OF FACTS:

Petitioner began working for the Respondent on 9/30/08 as a welder/metal fabricator. He testified as to various equipment he used while working for the Respondent, including a 250-ton hydraulic brake press, a punching apparatus, hand-operated grinders, a drill press, hand-operated drills, and metal rolls. Alan Leard, president of the Respondent, also testified that the Petitioner utilized various small layout tools, such as tape measures, pencils, etc. Petitioner performed two different types of welding for the Respondent. This included TIG welding and MIG welding. Petitioner testified that cranes and equipment were available to perform heavier lifting activities. Alan Leard confirmed that cranes were available to lift heavy materials. Alan Leard testified that the Petitioner's position did not require constant, forceful gripping of tools. He testified as to the varied work activities the Petitioner performed and the varied tools utilized.

Prior to working for the Respondent, the Petitioner worked as a welder/metal fabricator for four to five years. One of the Petitioner's assignments for the Respondent was to construct a 20-foot long coal wash-down chute. Petitioner worked on this project for approximately three weeks. He described the chute as 2' x 3' x 20' long, constructed of quarter-inch stainless steel. Petitioner TIG welded all four sides of the chute together, and they were placed on horses. Part of his assignment required him to crawl inside the chute to perform some of the welding. He also performed welding on the outside of the chute. His equipment included a leather sleeve, a welding hood, gloves, and boots. He welded along each corner of the four-sided chute and completed approximately 1 foot of welding for every 15 minutes. He would take breaks as necessary and crawl in and out of the chute.

Another employee of the Respondent, Cory Zimmerman, worked in the same area as Petitioner. Cory Zimmerman would assist the Petitioner, if needed, such as with assisting with aligning the metal sheets. The metal sheets weighed approximately 150 to 200 pounds. The Petitioner did not lift the chute. Overhead cranes were utilized to roll or move the chute as necessary. Petitioner additionally performed welding on the outside of the chute.

Alan Leard testified that he was well aware of the Petitioner's job duties when he worked for the Respondent, including his construction of the coal wash-down chute. Petitioner performed some of his work activities outside of the chute, including assembly and welding, according to Alan Leard.

While completing the coal wash-down chute project, the Petitioner testified he noted muscle fatigue. He testified that on the night of 10/22/08, while sleeping at his home, he felt a sharp, stabbing pain in his right shoulder, which radiated into his right hand. He testified that he advised Ken Kapus, his foreman, the next day that he experienced this pain. According to Petitioner, Ken Kapus advised the Petitioner to present to Sherman Health Clinic. Alan Leard testified that the Petitioner advised him that he woke up in the middle of the prior night and only experienced right shoulder pain. He did not recall the Petitioner complaining of neck symptoms or hand/wrist symptoms.

The records from Sherman Health Clinic indicate the Petitioner presented on 10/24/08. (Petitioner's Exhibit No. 1.) These records indicate that the Petitioner awoke the night before with right arm pain. According to the records, the Petitioner complained of right upper arm pain. There are not noted to be any complaints or mention of the Petitioner's neck or lower arm/hand. Petitioner was diagnosed with right shoulder and right upper arm sprain/strain. He was provided Ibuprofen, an ACE bandage, and restricted to light duty. According to Alan Leard, the Petitioner's light-duty restrictions were always accommodated. The Petitioner claimed that the light-duty restrictions were not always accommodated.

The Petitioner continued to receive treatment at Sherman Health Clinic through 2/3/09 for rechecks on his right shoulder sprain. At certain points during his treatment at Sherman Health Clinic, the Petitioner was allowed to return to work without restrictions or provided less restrictive work restrictions. Alan Leard testified that the Respondent always abided by those restrictions. Petitioner continued to receive the diagnosis of right shoulder/arm strain. On pain diagrams completed by the physicians, the Petitioner was noted to have tenderness in his right shoulder and right upper arm. There were never noted to be any complaints regarding the Petitioner's cervical spine. The Petitioner underwent physical therapy at Sherman Health Rehabilitation Services as well. (Petitioner's Exhibit No. 1.) The physical therapy records note complaints of symptoms in the right shoulder and the right arm.

Throughout his treatment at Sherman Health Clinic, the Petitioner was noted to have positive signs for right shoulder impingement. An MR arthrogram was performed of the right shoulder on 1/28/09 with no evidence of a rotator cuff tear or labral tear. It was noted to be a normal right shoulder MR arthrogram. For the first time referenced in the medical records, on 2/03/09, the Petitioner was noted to be complaining of right hand symptoms. The Petitioner was referred to Dr. Freedberg for an orthopedic evaluation.

Dr. Freedberg at Suburban Orthopedics first treated the Petitioner on 2/05/09. (Petitioner's Exhibit No. 2.) On a Medical History Intake form, the Petitioner noted the reason for his visit was his right shoulder. The Petitioner was noted to have occasional sharp pains but more of a steady/aching right shoulder. Most of his discomfort was in the anterior aspect of his right shoulder. He also noted that he had shooting pain down his right arm to his fourth and fifth fingers and intermittently to his thumb. Dr. Freedberg noted a negative median nerve compression test. He diagnosed right biceps tendinitis, right shoulder impingement, and possible cervical radiculopathy. He recommended injections to the shoulder, an EMG, and prescribed Celebrex and a Medrol Dosepak. The Petitioner deferred on the Cortisone injection.

An EMG was performed on 2/09/09, which noted no cervical radiculopathy. (Petitioner's Exhibit No. 2.) The Petitioner was noted to have mild median neuropathy bilaterally. In follow-up, Dr. Freedberg diagnosed right carpal tunnel syndrome, right biceps tendinitis, right shoulder impingement, and possible cervical radiculopathy. Dr. Freedberg eventually performed a corticosteroid injection into the subacromial space of the right shoulder on 3/24/09. He continuously provided the Petitioner with the same diagnoses and continuously noted a negative median nerve compression test. On 4/29/09, the Petitioner noted he was doing much better following the shoulder injection and was noted to be 70 to 80 percent better. Dr. Freedberg was hopeful to return the Petitioner to full-duty work at the next appointment. Petitioner was noted to still be complaining of pain in his neck. This is the first time that the Petitioner's neck complaints are noted anywhere in the medical records.

The Petitioner testified that he stopped working for the Respondent in May of 2009. He was laid off due to a lack of work. He testified that he had the same complaints, including cervical spine and shoulder pain. He indicated that he was released to full duty work. He noted that had to pay bills and had found out that his wife was pregnant.

On 6/03/09, Dr. Freedberg noted the Petitioner was doing fine with respect to his shoulder but that his neck was not doing well. Petitioner noted 90 to 100 percent improvement in his right shoulder. Petitioner's neck complaints appeared to become more prominent at this time. Dr. Freedberg continued to prescribe Celebrex and also noted the Petitioner could return to work full duty at that time. Physical therapy was restarted in June of 2009, but Petitioner was discharged due to a lack of progress.

Dr. Freedberg performed a second right shoulder injection on 7/08/09. A cervical MRI was performed on 7/22/09, which noted a minor bulge of the disc at the C3-C-4 level. On 7/30/09, Dr. Freedberg noted that the

Petitioner was continuing to make complaints of headaches and neck pain. The Petitioner was noted to have pain between his shoulder blades and was noted to occasionally feel numbness, tingling, and pain down into his right hand. Dr. Freedberg noted the Petitioner's shoulder was not painful at that time. He also noted the Petitioner was not doing well with respect to his neck and shoulder, but he cleared the Petitioner to return to work regular duty. Dr. Freedberg continued to note a negative median nerve compression test and continuously provided a diagnosis of right carpal tunnel syndrome, right biceps tendinitis, right shoulder impingement, and possible cervical radiculopathy.

The Petitioner then obtained employment at High Grade Welding in Elk Grove Village starting on 8/15/09. He worked as a welder/fabricator. He testified that he noted pain in his neck and right shoulder. He worked for approximately one month at High Grade Welding.

The Petitioner next obtained employment at Technology One Welding on 2/04/10. (Respondent's Exhibit No. 6.) He again worked as a welder/fabricator.

The Petitioner sought no medical treatment again until 3/08/10 when he returned to Dr. Freedberg. He testified he did not seek treatment because he had no way to pay for the medical treatment. The Petitioner noted his pain was now worse with the return to work the previous month. He was still experiencing pain in the neck and right shoulder, pain shooting down his arm, and headaches. Dr. Freedberg prescribed Diclofenac, a Medrol Dosepak, and physical therapy. He provided the same diagnosis as before and again noted the Petitioner could return to full-duty work. On 5/03/10, Dr. Freedberg recommended a right shoulder arthroscopy and biceps tenodesis, as he noted conservative treatment had failed. He again noted the Petitioner could perform full duty work. The Petitioner continued to work throughout 2010 at Technology One Welding.

The Petitioner then did not treat again until 3/31/11 with Dr. Freedberg. The Petitioner was making complaints of pain over the right arm and right shoulder with numbness down his entire arm, second, third, fourth digits, and right thumb. This is the first time the numbness is noted in that specific pattern in the fingers of the right hand. His median nerve compression test was again noted to be negative. Petitioner also continued to complain of pain between his shoulder blades as well as headaches. Dr. Freedberg continued to recommend shoulder surgery and provided the same diagnoses as always. On 5/12/11, Dr. Freedberg noted that the Petitioner's neck pain and upper back pain began within two weeks of the injury, not at the time of the injury. (Petitioner's Exhibit No. 5, p. 26.)

A second EMG was performed on 5/23/11, at the same facility, by the same physician as the prior EMG. (Petitioner's Exhibit No. 2.) The new EMG noted acute bilateral C5-C6 radiculopathy, which was more prominent on the right side, a finding not noted on the prior EMG. The Petitioner was also noted to have median neuropathy across the wrists and a new finding of mild left ulnar neuropathy across the elbow. Dr. Freedberg referred the Petitioner to Dr. McNally, also from Suburban Orthopedics, to treat the Petitioner's cervical radiculopathy.

The Respondent had the Petitioner evaluated by Dr. Charles Carroll on 7/18/11. (Respondent's Exhibit No. 4.) Dr. Carroll offered opinions solely with respect to the right shoulder, according to his report on pages 2 and 4.

The Petitioner alleged an injury to his right shoulder on 10/23/08 and localized the pain to the right shoulder, radiating into the arm. On examination, Dr. Carroll noted positive impingement sign in the right shoulder and tenderness over the anterior shoulder on the right. Dr. Carroll noted no evidence of nerve compression at the wrists. Petitioner did not complain of numbness in his hands or fingers.

Dr. Carroll felt that the Petitioner's right shoulder symptoms related in part to the injury alleged, although the persistence of his pain was noted to be multifactorial. He felt that the right shoulder surgery was appropriate to consider. He also felt the Petitioner could work without restriction at that time.

The Petitioner did follow up with Dr. McNally at Suburban Orthopedics for treatment of his cervical radiculopathy. On 7/21/11, Dr. McNally diagnosed cervical spinal stenosis, cervical disc displacement, and cervical disc degeneration. (Petitioner's Exhibit No. 2.) He prescribed a cervical spine MRI. That MRI was performed on 8/15/11, which again revealed a C3-C4 minor disc bulge, as was noted on the prior cervical MRI. The Petitioner continued to follow up with Dr. Freedberg and Dr. McNally in the fall of 2011. Dr. Freedberg was no longer diagnosing carpal tunnel syndrome. Petitioner continued to work at Technology One Welding as well. (Respondent's Exhibit No. 6.)

The Petitioner worked at Technology One Welding up until 12/02/11. On 12/02/11, Dr. Freedberg performed a right shoulder subacromial decompression, biceps tenodesis, and distal clavicle resection at St. Alexius Medical Center. (Petitioner's Exhibit No. 3.) The medical records indicate that Petitioner was much improved after the surgery. (Petitioner's Exhibit No. 2.) He eventually regained full range of motion by 4/16/12 and full strength as well. He was noted to be in very little pain by 3/12/12. The Petitioner also noted by 6/11/12 that he felt he could return to full-duty work. Dr. Freedberg allowed the Petitioner to return to full-duty work on 6/11/12. Petitioner testified as to 80 percent improvement in his right shoulder.

The Petitioner then obtained employment at Sound Performance as a welder/ fabricator/mechanic. As the Petitioner's neck allegedly remained painful following the right shoulder surgery, Dr. Freedberg recommended that the Petitioner undergo a cervical epidural steroid injection. The Petitioner began treating with Dr. Novoseletsky, a pain management physician at Suburban Orthopedics, in the fall of 2012. Dr. Novoseletsky performed a cervical epidural steroid injection, a greater occipital nerve block and a medial branch block in the cervical spine during the fall of 2012. A third EMG was performed on 11/05/12, which was negative for cervical radiculopathy but noted mild cubital tunnel syndrome and possible bilateral carpal tunnel syndrome.

On 11/12/12, Dr. Novoseletsky again performed a medial branch block, and the Petitioner noted 75 percent relief with that injection. In follow-up to Dr. Novoseletsky, the Petitioner noted on 11/14/12 that 90 percent of his pain was coming from his neck and 10 percent from his shoulder. Dr. Novoseletsky also performed a cervical radiofrequency neurotomy on 12/12/12. Petitioner noted the pain in his right arm was better following that procedure, but he still complained of neck pain and headaches radiating up from the neck to the back of the skull. Petitioner was to follow up with Dr. Novoseletsky.

The Petitioner continued to note that he was doing well with respect to his right shoulder, as noted by Dr. Freedberg on 12/19/12. Dr. Freedberg placed the Petitioner at maximum medical improvement for his right shoulder on 12/19/12.

The Petitioner last treated with Dr. Freedberg on 5/13/13. The Petitioner was again allowed to return to work without restrictions. Petitioner was noted to still be experiencing bilateral hand and wrist pain, numbness, and tingling of the bilateral fingers and pain radiating to the left elbow. Petitioner was noted to be doing well with respect to his right shoulder. For the first time, Dr. Freedberg noted positive elbow Tinel's and Phalen's signs and a positive median nerve compression test. Dr. Freedberg diagnosed cervical radiculopathy, right shoulder bicipital tendinitis status post right shoulder surgery, and left greater than right carpal tunnel syndrome with left DeQuervain's syndrome. Dr. Freedberg noted a left carpal tunnel release with release of the first dorsal compartment and possible tendon repair as a potential treatment option.

The Petitioner last treated with Dr. McNally at Suburban Orthopedics on 6/13/13. (Petitioner's Exhibit No. 2.) The Petitioner's chief complaint was of his cervical spine, and he noted left wrist pain and headaches. Dr. McNally diagnosed the Petitioner with small disc protrusions at C3-4 and T1-2 without significant interval change. This was based on his reading of a third cervical MRI that was performed on 5/21/13. Dr. McNally diagnosed carpal tunnel syndrome, cubital tunnel syndrome, cervical spinal stenosis, cervical disc displacement, cervical disc degeneration, occipital neuralgia, and DeQuervain's tenosynovitis. He recommended the Petitioner follow up with Dr. Freedberg for the carpal tunnel and DeQuervain's treatment, pain management with Dr. Novoseletsky, and to consider evaluation and treatment by a neurologist for headaches. This was the last time the Petitioner treated at Suburban Orthopedics.

An FCE was performed at Elite Physical Therapy on 8/14/13. (Petitioner's Exhibit No. 7.) There is no indication as to the physician who ordered the FCE, and it is noted that the Petitioner had no work restrictions when he completed his treatment at Suburban Orthopedics. According to the FCE, the Petitioner could function at the light physical-demand level, but it was also noted the Petitioner could benefit from participation in work conditioning.

The Petitioner next treated with Dr. Greenberg, an orthopedic surgeon, on 9/18/13. (Petitioner's Exhibit No. 6.) The Petitioner testified that he worked on Dr. Greenberg's vehicle at Sound Performance, and Dr. Greenberg recommended the Petitioner be seen at his office. Dr. Greenberg noted a three-year history of bilateral numbness and tingling in the low median nerve distribution. He also noted that the symptoms had been worsening over the past year. The numbness was worse in the left upper extremity. Dr. Greenberg diagnosed bilateral carpal tunnel syndrome, left worse than the right. He recommended a new EMG/NCV, a right wrist brace, Ibuprofen, and Aleve. This fourth EMG was performed on 11/05/12 and was noted to be essentially negative. It failed to reveal strong electrical diagnostic evidence of cervical radiculopathy. There was noted to be bilateral left more than right severe sensorimotor median nerve entrapment neuropathy at the wrist with signs of focal demyelination but without signs of acute denervation and mild axonal loss on the left side/severe carpal tunnel syndrome bilaterally. Additionally, there was noted to be mild right ulnar nerve entrapment neuropathy at the elbow/mild cubital tunnel syndrome.

Dr. Greenberg reviewed the results of the EMG on 1/29/14. Petitioner's major complaint that day was very mild left DeQuervain's tenosynovitis. Dr. Greenberg injected the left first extensor compartment. Dr. Greenberg recommended continued use of the left night thumb spica splint and right wrist splint at night with hand elevation. He recommended the Petitioner follow up in three weeks. The Petitioner never followed up with Dr. Greenberg.

The Petitioner has not treated with any physician since 1/29/14. He has no follow-up appointment scheduled with any physician. He currently has no work restrictions from any physician. The records indicate that his treating physicians have released him to work full duty.

The Petitioner continues to work at Sound Performance as a welder/fabricator/mechanic, and he testified he mainly performs TIG welding. He testified that he still notices neck pain when looking up, muscle weakness in his arms, and difficulty trusting his right shoulder in performing activities. He testified that he does not have as much muscle strength as he did before the alleged accident and cannot perform welding activities for as long of periods of time due to neck pain. Petitioner testified that the injection performed by Dr. Greenberg on 1/29/14 provided relief but that his numbness and tingling came back.

The Petitioner presented Dr. Freedberg for his evidence deposition on 10/23/12. (Petitioner's Exhibit No. 5.) Dr. Freedberg testified with respect to his treatment of Petitioner starting on 2/05/09. Dr. Freedberg testified

that there was a direct causal connection between the Petitioner's injury that occurred in October of 2008 and the right shoulder surgery he performed based on the Petitioner's history, the mechanism of the injury, the persistent symptoms, and the fact that the Petitioner's shoulder was doing great following the shoulder surgery. (Petitioner's Exhibit No. 5, pp. 31-32.) Dr. Freedberg also testified that there was a causal connection between the Petitioner's current condition of ill-being in his cervical spine and the alleged work accident based on the combination of the Petitioner's history and the persistent chronology of events of issues that he was experiencing. (Petitioner's Exhibit No. 5, p. 35.)

On cross-examination, it must first be noted that Dr. Freedberg was largely obstructive. He noted he was not aware that the medical records from Sherman Hospital do not document complaints of neck pain. (Petitioner's Exhibit No. 5, p. 40.) He also noted a history obtained from the Petitioner of crawling 360 feet through tight casing to perform the welding activities for the Respondent. (Petitioner's Exhibit No. 5, p. 42.) He admitted the original EMG from 2/09/09 did not reveal any cervical radiculopathy. (Petitioner's Exhibit No. 5, pp. 49-50.) He admitted the EMG that was then performed on 5/23/11 revealed acute bilateral C5-C6 radiculopathy. He admitted that the Petitioner improved regarding his right shoulder following the surgery with very little pain in his right shoulder by 3/12/12. (Petitioner's Exhibit No. 5, p. 53.) Dr. Freedberg testified he was deferring to Dr. McNally to treat the Petitioner's cervical spine issues. (Petitioner's Exhibit No. 5, p. 54.)

The Respondent presented Dr. Butler for his evidence deposition on 12/07/12. (Respondent's Exhibit No. 1.) Dr. Butler testified that he examined the Petitioner and prepared a report on 8/14/09 and additionally prepared a supplemental report dated 9/27/09. (Respondent's Exhibit No. 1, pp. 8-9.) He obtained a history directly from the Petitioner and reviewed the Petitioner's medical records from Sherman Health and Dr. Freedberg. He performed a physical examination on the Petitioner. The Petitioner provided Dr. Butler with the alleged injury date of 10/23/08. He noted it did not appear that the Petitioner's neck was an issue in the records from Sherman Health on 10/24/08 and also noted there was no diagnosis with respect to his cervical spine in the records from Sherman Health. (Respondent's Exhibit No. 1, pp. 11-12, 22-23.) Dr. Butler diagnosed the Petitioner with essentially a normal neck and some possible shoulder impingement. (Respondent's Exhibit No. 1, pp. 14-15.) He did not note any objective abnormalities with respect to the Petitioner's neck or with respect to his neurological examination. There were additionally no signs of radiculopathy. (Respondent's Exhibit No. 1, p. 15.) He felt the Petitioner had an excellent prognosis based on his normal MRI of the cervical spine and no anatomic abnormalities.

Dr. Butler testified that he did not find the Petitioner's condition of ill-being with respect to his cervical spine to be causally related to Petitioner's alleged work injury from October 2008. (Respondent's Exhibit No. 1, p. 15.) Dr. Butler felt there were subjective complaints that were more related to the Petitioner's right shoulder, and he did not find anything specifically abnormal in his neck upon MRI imaging, EMG, or physical exam. He also noted the Petitioner's neck was not aggravated or accelerated by the Petitioner's alleged October 2008 work injury. (Respondent's Exhibit No. 1, pp. 15-16.) He did not believe the Petitioner required any additional treatment to his cervical spine, noted the Petitioner was at MMI with respect to his cervical spine, and could return to full duty as it related to the neck. (Respondent's Exhibit No. 1, pp. 16-17.) On 9/27/09, Dr. Butler again reviewed the MRI of the cervical spine and noted it showed a minor bulge with no herniated disc at C3-C4. (Respondent's Exhibit No. 1, p. 17.) He felt this really had no correlation with the Petitioner's complaint of pain or any specific work injury.

On cross-examination, Dr. Butler affirmed that the records from Sherman Health do not indicate complaints of neck pain, and the Petitioner's complaints appeared to be related to the shoulder. Dr. Butler noted he had deferred the Petitioner to a shoulder specialist to evaluate the Petitioner's shoulder. (Respondent's Exhibit No. 1, pp. 40, 67; Respondent's Exhibit No. 1, pp. 23-25.) He noted the Petitioner's symptoms could have been

related to carpal tunnel issues. (Respondent's Exhibit No. 1, pp. 28-29.) He did not believe that the Petitioner's medical records from October and November of 2008 reflected radicular complaints of the hand and arm. (Respondent's Exhibit No. 1, p. 30.) He also noted that the Petitioner's complaints of hand and finger numbness on 2/05/09 with Dr. Freedberg were not consistent with carpal total syndrome. He noted that if there was any aggravation of the Petitioner's cervical spine condition, it was a temporary aggravation, but he noted he did not see that there was any causally connected injury to the neck. His symptoms appeared to emanate from the shoulder, the neck symptoms were very nonspecific, and the diagnostic testing was essentially normal. (Respondent's Exhibit No. 1, pp. 59-60.) His opinion was not affected by the Petitioner's continued alleged radicular complaints of pain after the right shoulder surgery. He also noted that the medical records do not support the presence of a well-defined radiculopathy. (Respondent's Exhibit No. 1, p. 61.)

On redirect examination, Dr. Butler confirmed that the Petitioner's condition of ill-being with respect to his cervical spine is not causally related to the October 2008 work accident because the Petitioner's complaints appeared to emanate primarily through the shoulder, and there was not a well-defined neck injury. Additionally, the MRI revealed only a nonspecific bulge at C3-4, and the Petitioner essentially had a normal EMG as well. (Respondent's Exhibit No. 1, p. 65.) He also noted he did not believe the Petitioner's continued cervical complaints in the year 2012 had anything to do with the injury described in 2008. (Respondent's Exhibit No. 1, p. 68.)

Respondent introduced into evidence a payment summary dated 3/27/14 from United Fire Group, the Respondent's workers' compensation carrier. (Respondent's Exhibit No. 5.) The payment summary documents the Respondent's payment of the medical bills related to the Petitioner's initial treatment at Sherman Health Clinic, payment of medical bills related to Petitioner's treatment at Suburban Orthopedics, and payment of the medical bills related to the right shoulder surgery and treatment following that surgery. The payment summary also documents the Respondent's payment of TTD benefits following the right shoulder surgery from 12/02/11 through 6/10/12.

The Petitioner introduced into evidence the alleged unpaid medical bills on this matter as well as a lien from Blue Cross/Blue Shield. (Petitioner's Exhibit No. 8.)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that he noted muscle soreness in his right upper extremity on 10/22/08 while working for Respondent on a coal wash-down chute. He advised Dr. Carroll that he noted severe pain while welding in a very tight tube and duct. He further testified that he woke up with severe pain in his right upper extremity the night of 10/22/08. The Petitioner injured his right upper extremity during the course of the workday and then experienced some delayed symptoms in the right upper extremity that evening.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he sustained accidental injuries arising out of and in the course of his employment on October 23, 2008.

WITH RESPECT TO ISSUE (E), WAS TIMELY NOTICE OF THE ACCIDENT GIVEN TO THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner testified that he advised Ken Kapus, his foreman, on the day after he noted the pain in his right upper extremity, that he had experienced this pain. Respondent's witness Alan Leard also testified that Petitioner advised him of the pain the day after Petitioner experienced the pain.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved by a preponderance of the credible evidence that he provided proper and adequate notice of the accident, and that Respondent failed to prove that it was somehow prejudice by any defect in said notice.

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

The Arbitrator finds that the Petitioner proved causal connection with respect to his right shoulder only. The Petitioner failed to prove causal connection with respect to his neck and bilateral hands/wrists/fingers.

With respect to the right shoulder, the Arbitrator notes the Petitioner made consistent complaints of right shoulder pain following the work accident. These complaints of right shoulder pain are documented in the records from Sherman Health Clinic and the records from Suburban Orthopedics. The Petitioner was also diagnosed with a right shoulder sprain during his treatment at Sherman Health Clinic. When the Petitioner began treating with Dr. Freedberg in February of 2009, he continued to complain of right shoulder symptoms. Additionally, Dr. Carroll, Respondent's Section 12 examiner, felt the Petitioner's right shoulder symptoms related in part to the injury alleged. Dr. Freedberg additionally testified that Petitioner's right shoulder condition was causally related to the October 2008 work injury. Based on Dr. Carroll's opinions, Dr. Freedberg's opinions, and based on the medical records from Sherman Health Clinic and Suburban Orthopedics, the Arbitrator finds that Petitioner proved causal connection with respect to his right shoulder.

The Petitioner failed to prove causal connection with respect to his neck/cervical spine. The Arbitrator bases this finding on numerous facts in the record. First, when the Petitioner reported the injury to Alan Leard, he specifically noted that he experienced pain in the right shoulder and did not identify pain in any other body part. Second, the Petitioner never complained of neck pain throughout his treatment at Sherman Health Clinic from October 2008 through February 2009, which supports Alan Leard's testimony. Petitioner's complaints and documented symptoms were specifically noted to be in the right shoulder and right upper arm, as noted in the Findings of Fact. Pain diagrams never noted pain over the neck area. Additionally, the diagnosis he received from Sherman Health Clinic was continuously noted to be right shoulder/arm strain. There was never a diagnosis provided with respect to his neck. Dr. Freedberg even noted on 5/12/11 that the Petitioner's neck pain did not begin at the time of the accident but rather "within two weeks" of the injury.

Third, when Petitioner presented to Dr. Freedberg on 2/05/09, he specifically noted on a Medical History Intake form he was being seen for his right shoulder. There is no reference to Petitioner's neck on that form. Fourth, radiographic testing does not support Petitioner's alleged neck injury. The initial EMG that was performed on 2/09/09 revealed no evidence of cervical radiculopathy and did not support Dr. Freedberg's continued diagnosis of "possibly cervical radiculopathy." The second EMG performed on 5/23/11, at the same facility performed by the same physician, now noted acute bilateral C5-C6 radiculopathy. This was a new finding as compared to the prior EMG that appeared well after the Petitioner was laid off by Respondent and had been working for other employers as a welder/fabricator. The cervical MRI's were also essentially negative and do not correlate with Petitioner's subjective complaints. The 7/22/09 and 8/15/11 cervical spine MRI's noted only a minor bulge at the C3-C4 level. There were no objective findings to support any alleged neck complaints or pain radiating down Petitioner's right arm emanating in the neck.

Fifth, The Petitioner's first documented specific complaint of neck pain does not occur until 4/29/09, six months after the work accident. Dr. Freedberg noted on 4/29/09 that the Petitioner was still complaining of neck pain, but this is the first time he specifically referenced Petitioner's complaints of neck pain. Additionally, Petitioner's neck complaints then became more prominent after he was laid off by Respondent in May of 2009. The Arbitrator finds the opinions of Dr. Butler to be more persuasive than Dr. Freedberg with respect to the neck. Dr. Butler is a physician who specializes in the treatment of the spine and spine surgery. (Respondent's Exhibit No. 1, p. 6.) Dr. Freedberg, on the other hand, admitted that he was deferring the treatment of Petitioner's cervical spine to his partner, Dr. McNally. (Petitioner's Exhibit No. 5, p. 54.) It must be noted that Dr. McNally offered no causation opinions regarding the cervical spine.

Dr. Butler's opinion that the cervical spine condition, which was essentially normal, was not causally related to the October 2008 work injury is well supported by the lack of neck complaints in the records most contemporaneous with the injury date. He noted the Petitioner's subjective complaints were related to the shoulder, and there were no objective findings to support neck complaints based upon the initial EMG testing, the MRI testing, and his physical examination of Petitioner. Dr. Butler's opinions stood up to cross-examination, as he noted the initial medical records do not reflect specific findings consistent with cervical radiculopathy or neck complaints. He maintained this opinion and noted his opinion was not affected by the fact that Petitioner made neck complaints following the shoulder surgery.

Dr. Freedberg's opinion regarding the cervical spine, on the other hand, was based in part on Petitioner's alleged persistent complaints. Again, the records fail to support persistent complaints regarding the neck. Dr. Freedberg also admitted he was unaware of Petitioner's lack of complaints of neck pain while at Sherman Hospital. He also claimed the Petitioner crawled 360 feet through the chute on which he was working when Petitioner testified the chute was only 20 feet long.

If the Petitioner was attempting to proceed based on an alleged repetitive trauma theory, the Arbitrator finds that the Petitioner still has failed to prove causal connection with respect to the cervical spine. No physician, including Dr. Freedberg, offered an opinion based on a repetitive trauma theory. The Arbitrator also notes the Petitioner's job duties to be varied, and the time spent working on the coal wash-down chute was simply not long enough to cause a repetitive trauma-type injury to the neck. The Petitioner testified that he only worked on the coal wash-down chute for approximately three weeks. Additionally, he did not spend all of his time inside the chute. He testified that he also spent time outside the chute using various equipment and tools, such as the brake press, and he also performed welding on the outside of the chute. The job duties were too varied, and not enough time elapsed for the Petitioner's neck injury to be causally related to repetitive trauma.
Based on the above, the overwhelming evidence illustrates that Petitioner's neck condition is not causally related to the alleged work injury, and the Arbitrator must find that the Petitioner failed to prove causal connection regarding his neck.

The Arbitrator must also find that the Petitioner's alleged bilateral carpal tunnel syndrome is not causally related to the October 2008 work accident. First, no physician offered any causation opinion regarding the Petitioner's carpal tunnel syndrome. Petitioner specifically elicited opinions from Dr. Freedberg regarding the Petitioner's neck and right shoulder condition. Dr. Freedberg never offered an opinion regarding the cause of the bilateral carpal tunnel syndrome. Dr. Greenberg, who treated the Petitioner solely for his bilateral hands/wrists, additionally offered no causal connection opinion. In fact, Dr. Greenberg obtained a history from Petitioner that his symptoms in his hands began three years prior, in 2010, and became worse within the last year. The Petitioner had long been laid off from Respondent when these symptoms allegedly began and, in fact, worked for three different employers as a welder/ fabricator since that time.

As noted with the alleged neck injury, when the Petitioner reported the injury to Alan Leard, he specifically noted that he experienced pain in the right shoulder and did not recall Petitioner alleging pain in any other body part. The records most contemporaneous with the accident date do not document any hand/wrist complaints and support Alan Leard's testimony. When the Petitioner treated at Sherman Hospital, the Petitioner did not complain of hand/wrist pain until 2/03/09, over three months after the alleged accident. Again, the Petitioner's complaints and documented symptoms were specifically noted to be in the right shoulder and right upper arm, as noted in the Findings of Fact. Pain diagrams of the physicians never noted pain over the hand/wrist area.

Additionally, the diagnosis he received from Sherman Health Clinic was continuously noted to be right shoulder/arm strain. There was never a diagnosis provided with respect to his hands/wrists. These records do not support Petitioner's testimony that he experienced pain radiating into his hand the night of 10/22/08. The Petitioner's EMG from 2/09/09 showed mild median neuropathy bilaterally, which led to Dr. Freedberg diagnosing right carpal tunnel syndrome. It is unclear why Dr. Freedberg only initially diagnosed right carpal tunnel syndrome, since he based the diagnosis on the EMG, and the EMG showed the mild median neuropathy to be bilateral. Dr. Freedberg's examinations also do not clearly show symptoms consistent with carpal tunnel syndrome until years later, as he continuously noted negative median nerve compression tests until his 5/13/13 examination.

Dr. Freedberg diagnosed the bilateral carpal tunnel syndrome, left greater than right, on 5/13/13. This is the first time he noted the left carpal tunnel syndrome. Dr. Greenberg also noted Petitioner's symptoms were worse in his left hand. Petitioner did not testify to left hand symptoms at any time while he worked for Respondent as well. Since the Petitioner never complained of his left hand/wrist while he worked for Respondent and the diagnoses regarding the left carpal tunnel was not noted until years later, the left carpal tunnel syndrome cannot be related to Petitioner's work injury.

Dr. Butler noted during his deposition that Petitioner's initial symptoms could have been related to a right carpal tunnel syndrome. However, he did not provide any causation opinion regarding the carpal tunnel syndrome. He also noted Petitioner's subsequent examinations and symptoms were not consistent with right carpal tunnel syndrome.

If Petitioner is attempting to proceed under a repetitive trauma theory regarding his hands/wrists, this argument must fail as well. The Petitioner only performed the work duties in the coal wash-down chute for a period of three weeks, far too short a time period to develop carpal tunnel syndrome. Additionally, Petitioner's job duties for the Respondent were varied. He utilized various equipment during his employment with Respondent, including various small layout tools. The Respondent further provided cranes to perform the heavy lifting, and Petitioner was provided assistance from other employees to perform any heavy lifting. The Petitioner did utilize equipment such as hand-operated drills, hand-operated grinders, and welding wands, and he was required to crawl in and out of the coal wash-down chute when working in the chute. However, according to Alan Leard, the Petitioner's job duties did not require constant, forceful gripping of tools and involved varied work activities with varied tools. This, in combination with the Petitioner's three-week period of work prior to the alleged symptoms of carpal tunnel syndrome, must lead the Arbitrator to conclude that Petitioner's work for Respondent did not cause Petitioner's carpal tunnel syndrome, even if proceeding under a repetitive trauma-type theory.

The Petitioner also worked as a welder/fabricator for four to five years prior to working for the Respondent, and he continued to work as a welder/fabricator following his work for Respondent, when his symptoms, especially the symptoms in the left hand, became consistent with carpal tunnel syndrome. These symptoms did not occur while Petitioner was working for Respondent.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner proved that his current condition of ill-being with respect to his right shoulder is causally related to the accident on October 23, 2008, but that Petitioner failed to prove by a preponderance of the credible evidence that his current conditions of ill-being with respect to his neck/cervical spine as well as his right and left hands/wrists/fingers are related to said 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:

Petitioner introduced into evidence Petitioner's Exhibit No. 8, a list of the alleged unpaid medical bills as well as a lien from Blue Cross/Blue Shield. The Respondent introduced into evidence Respondent's Exhibit No. 5, a payment summary from United Fire Group. This record documents Respondent's payment of medical bills from Sherman Hospital, Suburban Orthopedics, and Alexian Brothers Hospital. As noted above in Section (F), only the Petitioner's right shoulder condition is causally connected to the work injury. The Respondent is thus only responsible for outstanding medical bills related to the right shoulder. The records document no outstanding bills from Sherman Health Clinic or Alexian Brothers Hospital. The Respondent also paid a majority of the medical bills from Suburban Orthopedics. The only outstanding medical bills from Suburban Orthopedics that are related to the right shoulder are a small portion of physical therapy bills following the right shoulder surgery and some follow-up visits with Dr. Freedberg. These bills, per the fee schedule, total $2,929.02, as reduced to the fee schedule by the parties pursuant to Arbitrator's Exhibit No. 2.

Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner is entitled to reasonable and necessary medical expenses relating to treatment to the right shoulder in the amount of $2,929.02 pursuant to §8(a) and the fee schedule provisions of §8.2 of the Act. The other medical bills are unrelated to the right shoulder and are hereby denied. The Blue Cross/Blue Shield lien is related to the Petitioner's hand/wrist treatment and is also denied.

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

Petitioner claims to be entitled to TTD from 5/02/09 through 6/03/09, and from 12/02/11, the date of his surgery, through 6/11/12, following Dr. Freedberg's release to return to full-duty work following the surgery. Petitioner was on light-duty restrictions with respect to his right shoulder when he was laid off by the Respondent on 5/02/09. Dr. Freedberg then allowed Petitioner to return to full-duty work on 6/03/09. . The Petitioner was then restricted from work following his right shoulder surgery on 12/02/11. He was restricted from 12/02/11 until 6/10/12.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner was temporarily totally disabled from May 2, 2009 through June 3, 2009 and from December 2, 2011 through June 10, 2012, for a period of 32-1/7 weeks (including extra leap year day in 2012).

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

Petitioner experienced a right shoulder injury which resulted in surgery consisting of a right shoulder subacromial decompression, biceps tenodesis, and distal clavicle resection. The medical records, as noted

above, indicate that Petitioner was much improved in the right shoulder after the surgery. He eventually regained full range of motion by 4/16/12 and full strength as well. He was noted to be in very little pain by 3/12/12. The Petitioner also noted by 6/11/12 that he felt he could return to full-duty work. Dr. Freedberg allowed the Petitioner to return to full-duty work on 6/11/12. Petitioner testified as to 80 percent improvement in his right shoulder.

Petitioner has continued to work as a welder/metal fabricator following his return to work after the right shoulder surgery. He continued to note that his shoulder was doing well, as noted by Dr. Freedberg on 12/19/12 and at the time of his last treatment with Dr. Freedberg on 5/13/13. Dr. Freedberg placed Petitioner at MMI for his right shoulder on 12/19/12. He diagnosed right shoulder bicipital tendonitis and status post right shoulder surgery. Petitioner has no current work restrictions and no follow-up appointments scheduled with any physician.

Based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% person-as-a-whole, pursuant to §8(d)2 of the Act.

WITH RESPECT TO ISSUE (M), SHOULD PENALTIES BE IMPOSED UPON THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator finds that Respondent's conduct in the defense of this claim was neither unreasonable nor vexations under the circumstances so as to warrant the imposition of penalties. Therefore, based on the above, and the record taken as a whole, the Arbitrator finds that Petitioner's request for additional compensation pursuant to §19(l) and §19(k) and attorneys' fees pursuant to §16 of the Act is hereby denied.

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

Respondent introduced into evidence Respondent's Exhibit No. 5, a payment summary of medical and TTD payments made to date by United Fire Group. Respondent paid $12,572.19 in TTD benefits and $57,100.89 in medical benefits, according to Respondent's Exhibit No. 5. However, since only unpaid medical bills were requested by Petitioner, Respondent is not entitled to a credit for the remaining unpaid medical bills that were outstanding at the time of trial and that were awarded by the Arbitrator.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Thomas Kroll,
Petitioner,

vs.

NO: 13WC 27462

Concrete by Wagner, Inc.,
Respondent,

15IWCC0647

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, prospective medical, 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 August 15, 2014, is hereby affirmed and adopted.

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

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

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

DATED: AUG 21 2015
o081215
CJD/jrc
049

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

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

KROLL, THOMAS
Employee/Petitioner

Case# **13WC027462**

CONCRETE BY WAGNER INC
Employer/Respondent

15IWCC0647

On 8/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0598 LUSAK & COBB
JOHN E LUSAK
221 N LASALLE ST SUITE 1700
CHICAGO, IL 60601

0507 RUSIN MACIOROWSKI & FRIEDMAN LTD
RANDALL R STARK
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

19(b) ARBITRATION DECISION

THOMAS KROLL
Employee/Petitioner

Case #13 WC 27462

v.

15IWCC0647

CONCRETE BY WAGNER, 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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on July 29, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☐ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☐ Should penalties or fees be imposed upon the respondent?

M. ☐ Is the respondent due any credit?

N. ☒ Prospective medical care?

FINDINGS

- On August 5, 2013, the respondent was operating under and subject to the provisions of the Act.
- On this date, an employee-employer relationship existed between the petitioner and respondent.
- Timely notice of this accident was given to the respondent.
- In the year preceding the injury, the petitioner earned $88,441.60; the average weekly wage was $1,700.00.
- At the time of injury, the petitioner was 56 years of age, single with one child under 18.

ORDER:

- The petitioner's request for benefits is denied and the claim is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

August 15, 2014

Date

AUG 15 2014

FINDINGS OF FACTS:

The petitioner, a union employee, sought medical care for low back pain at South Suburban Hospital on August 5, 2013. He reported that he felt immediate sharp pain in his low back that radiated to his upper left chest and down to his left testicle after lifting a flat concrete. X-rays were negative for fractures or dislocations. Ultrasounds revealed a small hydrocele on both sides of his scrotum. He was discharged with prescriptions for pain medication. The petitioner sought treatment at Advocate Occupational Clinic the next day for left shoulder and radiating back pain. He reported feeling a pull and a jerk on the left side of his back and shoulder while stripping and throwing concrete forms onto a bank. The diagnosis was cervical spine sprain and myofascial syndrome of his lumbar spine. No work, medication and icing were recommended. On August 8th, the petitioner reported sharp back and left shoulder pain with radiation pain down his left leg, and tingling in his first three fingers and in his left hand. The diagnosis was not changed, the work restrictions were continued and physical therapy was started. The petitioner's primary complaint on August 15th was his left shoulder. The petitioner reported minimum improvement on August 22nd. On September 5th, his primary symptom was cervical spine pain. His primary concern on September 25th was back, left shoulder and leg pain and on October 21st, back and left shoulder pain. On November 6th, the petitioner's primary concern was back pain.

Dr. Kevin Walsh examined petitioner at the respondent's request on October 27th and opined that the petitioner's subjective complaints are not causally related to the reported incident. He opined further that the petitioner does not have any permanent restrictions or need further medical treatment, that he has reached MMI and that he can

return to work without any formal restrictions. The petitioner did not seek further medical care.

Surveillance video in February and March of 2014 depicts the petitioner shoveling snow, starting and using a snow blower, using his truck to remove snow and getting in and out of his vehicle without any difficulty.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that he sustained an accident on August 5, 2013, arising out of and in the course of his employment with the respondent. Douglas McCarthy, Todd Wawczak and Victor Ramirez rebutted the petitioner's testimony of stripping any concrete forms on August 5, 2013. Contrary to the petitioner's testimony, the credible evidence is that he was assigned and performed the duties of installing insulation on the concrete walls on August 5, 2013. The petitioner's request for benefits is denied and the claim is dismissed.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jaime Reese,

15IWCC0648

Petitioner,

vs. NO: 12 WC 10608

Metro East Industries,

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 medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015, is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

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

DATED: AUG 21 2015
O8/4/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0648

REESE, JAIME
Employee/Petitioner

Case# 12WC010608

METRO EAST INDUSTRIES
Employer/Respondent

On 1/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4933 SAUTER SULLIVAN LLC
MICHAEL L KNEPPER
3415 HAMPTON AVE
ST LOUIS, MO 63139

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0648

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Jamie Reese
Employee/Petitioner

v.

Metro East Industries
Employer/Respondent

Case # 12 WC 10608

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Belleville**, on **October 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **1/20/2012**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**46,918.47**; the average weekly wage was $**902.28**.

On the date of accident, Petitioner was **36** years of age, ***single*** with **1** dependent child.

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

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

Petitioner failed to prove that her current condition of ill-being in her lumbar spine is causally related to her accident of January 20, 2012. Petitioner's claim for prospective medical care and temporary total disability benefits is denied.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of: Memorial Medical Center (1/20/12), as provided in Section 8(a) and 8.2 of the Act. Respondent shall receive credit for amounts paid which satisfied all or part of any of these bills.

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.

Nancy Lindsay
Signature of Arbitrator

December 22, 2014
Date

ICArbDec19(b)

JAN 5 - 2015

Before the Illinois Workers' Compensation Commission

Jaime Reese,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case No. 12 WC 10608
	)	
Metro East Industries,	)	
	)	
Respondent.	)	

Findings of Fact and Conclusions of Law

Petitioner alleges that her work activities as a Material Coordinator caused or aggravated her lumbar condition resulting in the need for medical treatment, TTD benefits and future lumbar surgery. Respondent disputes all issues. Petitioner and Randy Tritch, Respondent's representative and Petitioner's supervisor, and Robert Schutte testified at the arbitration hearing.

The Arbitrator finds:

Petitioner worked for Respondent as a Tool Room Keeper between 1996 and 2000 and August 2004 and November 2007. Respondent promoted her to Material Coordinator on November 19, 2007. She worked for Respondent in that capacity until her termination on March 2, 2012.

Respondent sent Petitioner to Midwest Occupational Medicine on January 20, 2012. Petitioner reported a gradual onset of low back pain beginning in early December 2011 and worsening ever since. She denied any specific incident. Dr. Byler noted that she "has not had any slip or fall. She has not bent over in any odd way that bothered her." Petitioner suggested it could be secondary to driving a fork truck with bad shocks. Petitioner denied any pain with rest, noting that her pain usually began after she had been walking. Petitioner also denied any weakness, numbness, tingling, or radiation into her buttocks or legs. Petitioner's range of motion was noted to be quite good. Dr. Keith Byler's assessment was low back pain. The physical exam was normal and Petitioner was noted to be pain free. He diagnosed possible spinal stenosis. Dr. Byler opined he did not see any relation between her complaints and work activities. As he felt there was no work injury he recommended Petitioner consider following up with her primary care physician. (PX. 10)

On February 7, 2012, Petitioner saw her primary care physician, Dr. Phillip Conway, for the purpose of establishing medical care. Petitioner gave a history of depression for 20 years and for which she saw a psychiatrist. She also reported bouts of exertional lightheadness for a year which caused her to stop exercising. Previous x-rays had shown some mild disc narrowing of her lumbar spine and some aortic atherosclerosis. Cessation of smoking was discussed. Petitioner's active problem list included chronic depression and ADD. Petitioner reported intermittent trouble

with some back discomfort. Under "Systems Review - Musculoskeletal" it was noted: "Back discomfort has been evaluated by previous visit." The history lists her as a pack a day smoker for 15 years. Dr. Conway recommended Petitioner stop smoking, reduce her weight and undergo lab work. With regard to her back, Dr. Conway recommended Dr. Curylo. (PX. 5)

Petitioner was terminated in March of 2012.

Petitioner filed her Application for Adjustment of Claim in this matter on March 23, 2012. Petitioner alleged multiple injuries stemming from being injured in the course and scope of her employment on January 20, 2012. (AX 2)

A lumbar spine MRI was performed on April 25, 2012 and revealed findings regarding Petitioner's kidneys and a small left herniated disc at L3-4. (PX. 5)

On June 15, 2012, Petitioner saw Dr. Taylor. Petitioner gave a history of low back pain since December 2011 that she related to lifting up to 100 pounds overhead at work. Petitioner also reported an episode of loss of bowel or bladder in April. More specifically, Dr. Taylor noted the following:

> This individual describes a work environment and a work event where she was lifting quite heavy objects, some of them were down in crates. During her work experience in December, she had the onset of symptoms of back and leg pain which increased in severity and duration. She was evaluated by Dr. Bylar [sic] per her report. Dr. Bylar's note of 1/20/2012 has been reviewed. This individual's condition is consistent with lumbar ridiculopathy and discogenic back pain. Based on a reasonable degree of medical certainty, her symptoms were aggravated by her work exposure described to me and that work exposure is causally connected to her present symptomology and her need for treatment. (PX 3)

Dr. Taylor noted Petitioner's body mass index was 49.8. The physical examination was within normal limits other than decreased lateral bending by 50%. Dr. Taylor felt the MRI was of poor quality. Based upon Petitioner's description that her symptoms were aggravated by her work exposure, Dr. Taylor opined that Petitioner's work exposure was causally connected to her present symptomology and need for treatment. He recommended a high quality MRI and bilateral lower extremity EMG studies and referred Petitioner to a pain management specialist, Dr. Boutwell. (PX. 3)

Petitioner first saw Dr. Boutwell August 9, 2012. Dr. Boutwell's report from that date states:

> She states that her current constellation of symptoms are the result of an injury she sustained on 1/20/12 while working for Metro East Railroad repair shop ....On that date she was working as a material coordinator and first noticed symptoms in December of 2011. She continued to work in her line of duty which reported required frequent lifting of very heavy loads up to 60-80 pounds. She reported injury to her superiors in January of 2012 and was referred to Dr. Byler for initial care. (PX 6)

Dr. Boutwell recommended an L3-4 injection, physical therapy and medication. (PX 3)

On August 20, 2012, Dr. Boutwell performed a L3-4 epidural steroid injection and a right L4-5 transforaminal epidural space injection. Dr. Boutwell performed L3-4 epidural steroid injections on September 5, 2012 and September 17, 2012. On September 17, 2012 Dr. Boutwell also performed another L4-5 transforaminal injection. (PX 6)

Petitioner returned to Dr. Boutwell on September 19, 2012. She reported persistent low back pain and bilateral anterior and posterior leg discomfort. The symptoms were worse than at the first visit. She did not attend the recommended physical therapy because her car broke down. Dr. Boutwell opined that she would not recommend additional conservative measures in light of Petitioner's history of worsening symptoms. She prescribed continued medication and recommended Petitioner return to Dr. Taylor. (PX. 6)

On November 13, 2012, Petitioner returned to Dr. Taylor. She reported increased symptoms in her low back and lower extremities. At that time, he reviewed a job description Petitioner had provided to him and discussed her job history. His report from that date states "This individual's condition of discogenic back pain and radiculopathy are causally connected to her work exposure and her work exposure described to me has caused her symptomatology and her need for treatment." (PX 3) Dr. Taylor recommended updated testing including MRI scan, EMG studies and CT myelogram. (PX. 3)

On December 10, 2012, Petitioner underwent a Section 12 examination at Respondent's request with Dr. Sherman Wayne. Petitioner related her low back condition to a specific event in December 2011 when she lifted a 50 pound box of cup washers from a crate. Symptoms worsened when driving a forklift over uneven terrain. The physical exam performed by Dr. Wayne was within normal limits. Dr. Wayne recommended additional testing including the CT myelogram and EMG studies. He noted that she had significant risk factors for lumbar spondylosis with her morbid obesity and longtime tobacco abuse. He recommended that Petitioner undergo a supervised weight reduction program. He further noted the depression and associated magnified symptoms contributed to her complaints. (RX. 2)

On February 11, 2013, Petitioner underwent EMG studies of the lower extremities with Dr. Daniel Phillips. Dr. Phillips performed a physical examination that was within normal limits. The EMG study was normal and specifically did not disclose evidence of lumbar radiculopathy. (PX. 9)

The CT myelogram performed February 14, 2013, demonstrated hypertrophy at L4-5 and L5-S1 with moderate left greater than right L5-S1 and mild bilateral L4-5 foraminal stenosis. There was no evidence of lumbar disc herniation. (PX. 8)

Petitioner returned to Dr. Taylor February 19, 2013. He reviewed the studies and interpreted the CT myelogram to show bilateral foraminal stenosis at L4-5 and to a lesser degree L5-S1. He opined that Petitioner's foraminal stenosis was due to both facet hypertrophy and disc bulging. He recommended Petitioner exhaust non-operative treatment before considering surgery. He advised Petitioner that she needed to lose weight and decrease or stop smoking. (PX. 3)

On February 26, 2013, Petitioner returned to Dr. Boutwell. Dr. Boutwell noted that given the degenerative pathology in the setting of the high body mass index, Dr. Taylor felt (and she concurred) that Petitioner was a poor surgical candidate. Petitioner was taking ibuprofen and Dexedrine. Dr. Boutwell noted Petitioner was off work by her own volition. The physical exam was essentially unchanged from August 2012. Dr. Boutwell recommended nerve branch blocks and aquatic physical therapy. (PX. 6)

On March 4 and March 20, 2013, Dr. Boutwell performed bilateral L3-4, L4-5 and L5 nerve branch blocks. (PX. 6) Petitioner returned to Dr. Boutwell March 26, 2013. There was no change in her physical exam. Dr. Boutwell's assessment was consistent with spinal stenosis secondary to posterior element hypertrophy. Dr. Boutwell recommended against another set of injections because Petitioner had not been compliant with the recommendations for therapy and medication. Dr. Boutwell recommended Petitioner lose 100 pounds at a minimum prior to considering surgical intervention. (PX. 6)

On April 26, 2013, Dr. Wayne issued an addendum report following review of the EMG study and CT myelogram films. Dr. Wayne's diagnosis was L4-5 and L5-S1 chronic lumbar spondylosis with no evidence of disc herniation or nerve impingement. He opined Petitioner's current lumbar condition was causally related to her obesity, genetics and smoking history. Dr. Wayne explained that in the face of the extent of her disease, any activity of life whether at home or at work or recreation could produce temporary exacerbations of discomfort. Dr. Wayne opined lumbar surgery was neither reasonable nor necessary. (RX. 2)

On October 23, 2013, Petitioner returned to Dr. Taylor. She had started a new job that involved primarily billing and ordering with no repetitive lifting. At the October 23, 2013 appointment, Petitioner discussed with Dr. Taylor that she was working for a surgical instrument company, making surgical instruments. She stated she was not required to lift anything over 10 lbs. and that she primarily performed billing and ordering for the company. Dr. Taylor testified that he believed that Ms. Reese should continue to function in the light level. (PX 2, pg. 7) Dr.

Taylor went over the potential surgical options. He opined that the surgery could improve her symptoms but it would reduce her to the sedentary level at best. (PX 3)

Petitioner deposed Dr. Brett Taylor on November 6, 2013. On direct examination, Dr. Taylor opined that Petitioner's lifting and forklift activities would contribute to the aggravating effect on her condition. (PX. 2 at 15-16). Dr. Taylor testified that as of October 23, 2013, Petitioner was functioning on the light level and surgery would reduce her to the sedentary level of function. (PX. 2 at 17-18) On cross-examination, Dr. Taylor admitted that Petitioner's genetics and tobacco use contributed to the development of her arthritis. (PX. 2 at 21) He admitted that Petitioner's weight could be a factor in making her arthritic back painful. (PX. 2 at 22) He further opined that Petitioner had to be smoking less than 10 cigarettes a day for her to undergo fusion surgery. (PX. 2 at 23) Dr. Taylor admitted that Petitioner's low back and lower extremity symptoms worsened at each visit despite the fact that she had not worked for Respondent since March of 2012. (PX. 2 at 24-26) He testified that Petitioner's work activities for her new employer could irritate her lumbar condition no more than the activities of daily living. (PX. 2 at 27-28) Dr. Taylor admitted that he based his opinion on medical causation on Petitioner's job description that she did manual unloading and loading of trucks 70% of her work day. (PX. 2 at 32-33)

On January 13, 2014, Petitioner returned to Dr. Wayne for a Section 12 examination. There was no change in the physical exam. Dr. Wayne diagnosed chronic lumbar spondylosis greatest at the L5-S1 level bilaterally with mild to moderate foraminal stenosis. Dr. Wayne disagreed with Dr. Taylor that surgery was indicated in this case. He recommended that Petitioner lose 100 lbs, completely abstain from tobacco for 6 months and undergo a CT discogram from an independent radiologist. He also recommended Petitioner consult with a psychiatrist. (RX 1). His report did not address Petitioner's ability to return to work, and instead states "Due to the fact that I do not believe that it is work related disease that remains the patient's choice to what gainful employment she pursues." (RX 1) Dr. Wayne opined that there was no relationship between Petitioner's current lumbar condition and work activities for Respondent. He further opined that lumbar surgery was neither reasonable nor necessary. (RX. 2)

Respondent deposed Dr. Sherwin Wayne January 29, 2014. Dr. Wayne opined that taking Petitioner's job description into account there was no relationship between her current lumbar condition and work activity. He opined that the need for testing and treatment performed by Dr. Taylor and Dr. Boutwell was not related to her work activities for Respondent. Dr. Wayne explained that the worsening of symptoms after leaving Respondent's employment was consistent with the fact that the work for Respondent did not cause or aggravate her lumbar condition. (RX. 2)

At the arbitration hearing Petitioner testified that she is a 38 year old materials coordinator who began working for Respondent in 1996. She was laid off in 2000, but returned in 2004. In 2007 she was promoted to materials coordinator. Petitioner testified that as a materials coordinator she was responsible for organizing and storing all of the parts used by Metro East Industries, which builds and repairs rail cars. The vast majority of the parts she

handled were solid steel. As a materials coordinator, she was responsible for shipping and receiving and for all deliveries of materials to the business. The facility received deliveries of parts on a daily basis.

Petitioner testified that she unloaded crates from delivery trucks using a fork lift. Some crates contained all the same part, some crates contained different types of parts. The crates contained larger parts, packed individually, and smaller parts, which were packaged in boxes within the crates. Petitioner moved the crates to a canopied area of the facility where the parts were inventoried and stored. Then, she manually lifted the parts out of the crates and placed them in the appropriate bin or shelf. To do this, she had to bend and lift the part, or box of parts, out of the crate, and then lift and turn to place it in to the appropriate bin or shelf. Petitioner testified that there were thousands of different parts used and stored at the facility, which varied in weight from five or ten pounds up to one hundred pounds. Petitioner testified that although it varied from day to day, on average she spent approximately 50% of her day unloading parts. She was the only person who unloaded parts in the canopied area. The rest of her time was spent doing paperwork and computer work.

Petitioner testified that at her appointment with Dr. Taylor on October 23, 2013 she told Dr. Taylor that she was working at Katalyst Surgical. This job did not involve any heavy lifting and allowed Petitioner to sit as needed. It was her understanding that she could continue to work at that position, but that she should not lift any more than 10 lbs. Petitioner testified that it is her understanding that she remains under light duty restrictions of no lifting over 10 lbs. Petitioner testified that her work at the surgical instrument company ended when she was laid off on or about December 3, 2013. Following that date, she has not received any workers' compensation benefits and has not been able to find employment at any other job within her current restrictions.

Petitioner testified that on January 20, 2012 she started feeling pain in her lower back while putting away material. At first she thought it was a pulled muscle as she had on prior occasions. When the pain did not go away after a couple of days, she reported it to her supervisor. Eventually, she told her supervisor that she needed to see a doctor. Petitioner testified that January 20, 2012 was the day she went to the doctor. She then clarified that the pain began in December of 2011.

Petitioner testified that she developed low back pain in December 2011 manually lifting parts. The symptoms continued to worsen, including when driving a forklift, and she reported it as work-related January 20, 2012. Petitioner testified that the doctor at Midwest Occupational Medicine did not really offer her any treatment, other than ordering x-rays. He sent her back to work.

Petitioner testified that she was in constant pain. She was visibly upset at trial when discussing how her back injury had affected her. She testified that if she tries to walk too far her lower back hurts and if she doesn't stop what she is doing and sits down, pains start shooting down the front and backs her legs. She has trouble performing household activities and has

difficulty sleeping. Petitioner testified that she does not have a social life anymore. She no longer participates in sports or hiking.

Petitioner testified that she wants to undergo the surgery recommended by Dr. Taylor to "make the pain stop." She understands that she may never be able to perform the job she did at Metro East Industries again. She testified that she has cut back on her smoking as Dr. Taylor recommended, but did admit she has had a difficult time losing weight.

Petitioner testified that she had no prior injuries to her lower back nor had she ever been treated by any doctors for her lower back prior to January 20, 2012.

Tom Reese, Petitioner's father, testified via deposition taken on April 11, 2014. He worked 20 years as a general foreman for Respondent. He generally corroborated Petitioner's description of her work activities. (PX. 14)

Randall Tritch testified on behalf of Respondent. He testified that he was Petitioner's supervisor for the entire time she worked as a materials coordinator. Mr. Tritch testified that he did not dispute Petitioner's description of having to manually unload thousands of different parts. He confirmed that Petitioner was the primary person responsible for unloading parts in to the storage bins. He agreed that the amount of time spent unloading parts varied, and he estimated Petitioner spent three hours per day doing that work. Mr. Tritch testified that striker bars, which weighed 60 to 75 pounds had to be manually unloaded from the crates, but he had asked the supplier to stop shipping those parts in the bottom of crates in 2009 or 2010. He also told his workers to stop manually lifting those parts because they could get hurt. He confirmed that Petitioner reported having back pain although she could not pinpoint what happened.

Robert Schutte also testified on behalf of Respondent. He began working for Respondent in 1992, but is currently retired. He sometimes assisted Petitioner with unloading trucks. He testified that on some days, Petitioner would spend three or four hours unloading material, and on other days, she would do that almost the entire day. He confirmed that all the parts that were delivered had to be lifted out of the crates and stored. He testified that parts that weighed one hundred pounds or more would be lifted by a forklift. Mr. Schutte began driving a forklift in 1968 and admitted that he was much more skilled at driving a forklift than Petitioner. There were many parts that he was able to lift with a forklift that Petitioner could not lift with a forklift.

The Arbitrator concludes:

1. And 2. Disputed Issues C and F – Accident and Causation

Petitioner sustained an accidental injury arising out of and in the course of her employment because her work activities temporarily aggravated her pre-existing lumbar condition. However, Petitioner's current lumbar condition is not causally related to her accident.

Petitioner testified that she developed low back symptoms performing lifting activities for Respondent. While there is some dispute to the amount and frequency of the weight Petitioner lifted at work, Dr. Taylor opined the lifting could aggravate Petitioner's condition and Dr. Wayne acknowledged that any activity could temporarily aggravate the extent of Petitioner's pre-existing arthritic condition. The evidence supports the work temporarily aggravated Petitioner's condition.

Respondent terminated Petitioner March 2, 2012. Since that time, Petitioner's low back and lower extremity symptoms have continued to worsen. The symptoms worsened by Petitioner's admission with activities of daily living such as standing and walking. The worsening of symptoms despite the fact that Petitioner was no longer performing lifting for Respondent is inconsistent with the work being a permanent aggravating factor. The evidence supports the opinion of Dr. Wayne that Petitioner's current lumbar condition is causally related to her genetics, obesity and smoking history. Dr. Taylor admitted that Petitioner's weight could make her arthritic spine symptomatic.

The Arbitrator also finds significant the histories provided by Petitioner to Dr. Byler and Dr. Conway when compared to that of Dr. Taylor given on June 15, 2012. Petitioner expressly denied any problems associated with bending activities when seen by Dr. Byler. She also denied any radiating leg pain. When seen by Dr. Conway in February, Petitioner only mentioned occasional back pain. There was no mention of radiating leg pain. Dr. Conway prescribed nothing special in the way of treatment. Based upon this record, after seeing Dr. Byler in January, Petitioner underwent no further treatment for her back until June 15, 2012 (Dr. Conway really provided no treatment to Petitioner's back for a work-related problem on 2/7/12). In the interim, Petitioner was terminated and then filed her claim herein. Interestingly, Petitioner underwent a lumbar spine MRI in April of 2012. It is not know who ordered it or why it was ordered. The Arbitrator notes three interesting bits of history when Petitioner presented to Dr. Taylor in June of 2012. First, Petitioner was now experiencing radiating leg pain. Second, she told the doctor her neck and leg pain began in December. Third, she reported an episode of loss of bowel or bladder in April. Medical records pre-dating June of 2012 don't corroborate Petitioner's history of leg pain beginning in December. Also, the episode in April corresponds in time with an MRI being performed but, again, the circumstances surrounding this are a mystery. While Petitioner testified Dr. Conway ordered an MRI and referred her to Dr. Taylor the circumstances surrounding both are unknown. Petitioner provided no testimony and Dr. Conway's records in evidence provide no corroboration.

Petitioner sustained, at most, a temporary aggravation of a low back condition. She failed to prove a causal connection between her back condition and her accident after February 7, 2012. In so concluding the Arbitrator relies upon her analysis above and further notes Dr. Taylor's opinions were not based upon an accurate understanding of facts prior to June 15, 2012. In addition, Petitioner did not associate any back complaints with lifting duties when seen by Dr. Conway and Dr. Byler. That history, as provided to Dr. Taylor, emerged after retaining an attorney and filing her claim.

3. Disputed Issue E – Notice

The evidence supports January 20, 2012 as the manifestation or accident date. Therefore, Petitioner provided timely notice of a work accident.

4. Disputed Issue J – Medical Expenses

Petitioner proved a temporary aggravation to her lumbar condition. The medical bill for testing and treatment from Memorial Medical Center (1/20/12) is reasonable and necessary to evaluate and diagnose Petitioner's condition. Respondent shall pay the afore-mentioned bill subject to the Medical Fee Schedule.

The medical bills from 2/7/12 for the visit with Dr. Conway and lab work and for the transthoracic echocardiography from Mercy Hospital are not causally related to her work accident. Petitioner did not present to Dr. Conway on February 7, 2012 specifically requesting any treatment for ongoing back complaints Petitioner related to a work injury. Rather, she was establishing care. The medical bills for testing and treatment rendered by Dr. Brett Taylor, Pain and Rehabilitation Specialists of St. Louis, St. Louis Spine and Orthopedic Center and Walgreens, CT Partners of Chesterfield, and the Mercy Hospital bill of 4/25/12 and West County Radiology dated 4/25/12 are not causally related to the work accident. Therefore, Respondent is not responsible for those bills.

5. Disputed Issue K – Prospective Medical Care

Petitioner requests approval for an L4-5 and L5-S1 anterior-posterior fusion proposed by Dr. Taylor.

For the reasons above, Petitioner did not prove her current lumbar condition is causally related to the work accident.

Petitioner did not prove the lumbar surgery proposed by Dr. Taylor is reasonable and necessary. Both Dr. Taylor and Dr. Boutwell stated Petitioner is a poor surgical candidate secondary to her weight and smoking. Despite repeated recommendations to improve those issues, Petitioner testified she gained weight and continues to smoke. Dr. Boutwell noted on several occasions that Petitioner was not compliant with her treatment recommendations. Dr. Taylor admitted that surgery would make her less functional.

For the foregoing reasons, Petitioner's request for surgery is denied.

6. Disputed Issue L – TTD Benefits

Petitioner claims temporary total disability benefits from December 3, 2013, through October 29, 2014. Petitioner did not prove her current condition of ill-being and the need for any work restrictions are related to her work accident. Petitioner's claim for TTD benefits is denied.

****

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Alicia Burse,
Petitioner,

15IWCC0649

vs.

NO: 14 WC 11711

Elementary School District 159,
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, benefit rates, medical expenses, temporary disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015, is hereby affirmed and adopted.

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

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

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

DATED: AUG 21 2015
O8/12/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

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

15IWCC0649

BURSE, ALICIA
Employee/Petitioner

Case# **14WC011711**

ELEMENTARY SCHOOL DISTRICT 159
Employer/Respondent

On 1/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2988 CUDA LAW OFFICES
ANTHONY CUDA
6525 W NORTH AVE SUITE 204
OAK PARK, IL 60302

0863 ANCEL GLINK
TIFFANY NELSON-JAWORSKI
140 S DEARBORN ST SUITE 600
CHICAGO, IL 60603

15IWCC0649

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION
19(b)

ALICIA BURSE
Employee/Petitioner

v.

ELEMENTARY SCHOOL DISTRICT 159
Employer/Respondent

Case # **14** WC **11711**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Kurt Carlson**, Arbitrator of the Commission, in the city of **Chicago**, on **November 12, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

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

D. [ ] What was the date of the accident?

E. [ ] Was timely notice of the accident given to Respondent?

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

G. [ ] What were Petitioner's earnings?

H. [ ] What was Petitioner's age at the time of the accident?

I. [ ] What was Petitioner's marital status at the time of the accident?

J. [x] Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

K. [x] Is Petitioner entitled to any prospective medical care?

L. [x] What temporary benefits are in dispute?
[ ] TPD [x] Maintenance [x] TTD

M. [x] Should penalties or fees be imposed upon Respondent?

N. [x] Is Respondent due any credit?

O. ☐ Other

FINDINGS

On the date of accident, **3/5/14**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner **did not** sustain an accident that arose out of and in the course of employment.

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**52,000.00**; the average weekly wage was $**1,000.00**.

On the date of accident, Petitioner was **41** years of age, **married** with **2** dependent children.

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

Respondent shall be given a credit of $**0.00** for TTD, $**0.00** for TPD, $**0.00** for maintenance, and $**0.00** for other benefits, for a total credit of $ **39,453.17**.

Respondent is entitled to a credit of $**all bills paid by BCBS, the insurance carrier for insurance provided by the Respondent** under Section 8(j) of the Act.

ORDER

This is not a compensable claim.

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

Date 12.31.14

ICArbDec19(b)

JAN 5 - 2015

IN THE ILLINOIS WORKERS' COMPENSATION COMMISSION

ALICIA BURSE,	)	
	)	**15IWCC0649**
Petitioner,	)	
	)	
v.	)	**Case No.: 14 WC 11711**
	)	
ELEMENTARY SCHOOL DISTRICT 159,	)	
	)	
Respondent.	)	

ARBITRATION DECISION

I. FINDINGS OF FACT

Alicia Burse, the Petitioner ("Petitioner") testified that she works for the Respondent ("Respondent"), Elementary School District 159, located in Matteson, IL, as a Literacy Coach since 2011. (See p. 8-9 of the Transcript of the Proceedings, hereinafter cited as Tr. __). This is a teaching position. (Tr. 9). Her job duties include teaching teachers strategies to help their students with literacy issues. (Tr. 9). Her normal work hours are from 8 a.m. to 3 p.m. (Tr. 10). She worked three days a week at Mayra Yates School ("Yates") and two days a week at Seiden Prairie ("Seiden"). (Tr. 9, 187); (See Resp. Ex. 4, Petitioner's work schedule).

Petitioner testified that on March 5, 2014, she slipped and fell while she was walking through the parking lot of Yates while on her way to get lunch, then to a meeting at Seiden. (Tr. 14-16). She testified that she thought that she fell on ice. (Tr. 16). Petitioner stated that she hit her head on the parking lot ground. (Tr. 20).

On cross examination, Petitioner testified that she had no specific time to meet at Seiden but added that she had a later District Office meeting at 2 p.m. (Tr. 84-88). Her meeting at Seiden was at her discretion. (Tr. 84-88). Seiden is 5 to 7 minutes away from Yates and it also is about 7 to 9 minutes from the District Office. (Tr. 84-88).

Dr. Lisa Woods, the principal at Yates, testified that when Petitioner is assigned to a specific school, she usually stays at that school all day, unless she has a District meeting or she gets consent from the principal to leave and go to the other school. (Tr. 188-189). Petitioner testified that she does not have to alert anyone when she is leaving one school to go to another, yet this testimony was directly contradicted by Dr. Woods, who testified that Petitioner needs to inform her when she is leaving to report to another school during the hours that she is supposed to be working at Yates. (Tr. 14, 188-189). Petitioner also has to make up any time that she misses at Yates School for work that she does at Seiden School on days where she was assigned to Yates. (Tr. 188). On a regular basis, if assigned to a specific school, then she works only at that location and does not travel to another. (Tr. 188-189). However, on a monthly basis, the Petitioner attends District Office meetings, but those are not Fridays. (Tr. 189). The slip and fall occurred on a Wednesday. (Tr. 189). Dr. Woods testified that on the day of the accident, she was not informed that Petitioner was to travel to Seiden later that day. (Tr. 189-191).

The parties both submitted a video of Petitioner's fall as evidence in this case. (See Pet.'s Ex. 14; Resp.'s Ex. 1). The video shows a snow plow truck making a pass in the "drop off" area in front of the school. (See Pet.'s Ex. 14; Resp.'s Ex. 1). Instead of walking on the sidewalk or street which was plowed, the Petitioner makes a bee line to her car over the median where there is ice and snow. (See Pet.'s Ex. 14; Resp.'s Ex. 1). In her left arm, Petitioner appears to be carrying a bag or a purse and her right arm appears to be swinging. (See Pet.'s Ex. 14; Resp.'s Ex. 1). She does not appear to be carrying a file with papers in her right hand as she testified. (See Pet.'s Ex. 14; Resp.'s Ex. 1);(Tr. 17). Petitioner is walking at a normal to fast pace and she does not appear to be "tipping" or otherwise walking carefully as she testified. (See Pet.'s Ex. 14; Resp.'s Ex. 1); (Tr. 16). Petitioner then appears to walk over a snow covered median type

area and at the end of that area, yet still on the median, she slips and falls. It is not clear if she fell backwards, nor is it clear that she struck her head on the ground. (See Pet.'s Ex. 14; Resp.'s Ex. 1). Petitioner gets up immediately and does not lose consciousness. (See Pet.'s Ex. 14; Resp.'s Ex. 1). Again, it bears repeating that there was a street area that seemed to have been plowed and cleared of most snow. (See Pet.'s Ex. 14; Resp.'s Ex. 1).

After her fall, Petitioner testified that she staggered to her car and sat in her car and prayed. (Tr. 21). Despite there being a member of the Buildings and Grounds Department in the area plowing the main drive, Petitioner also testified that she was scared because no one was around to help her. (Tr. 21); (Resp. Ex. 1). The video does not show her staggering or stumbling. (Resp. Ex. 1). After praying, she called her husband who insisted that she not drive and instead told her to go back into the school and to go to the nurse's office. (Tr. 21). Petitioner testified that she then went to the nurse's office. (Tr. 21).

Despite Petitioner's husband testimony that her speech was slurred immediately after the accident, the school nurse, Geneva Gore, testified that she did not observe any slurred speech by the Petitioner. (Tr. 119, 155). Dr. Woods also noted that Petitioner was speaking normally and that her speech was not slurred. (Tr. 193). Nurse Gore further did not notice Petitioner walking differently or having any type of left-sided walk when she reported to the nurse's office immediately after her fall. (Tr. 155). Nurse Gore noted that Petitioner's area of pain seems to be the back of her head but while she did not notice any bleeding, broken skin, or swelling but she did give Petitioner an ice pack to prevent possible swelling. (Tr. 155-156).

Dr. Woods, the principal, then came to the nurse's office immediately after hearing about Petitioner's fall. (Tr. 1910192). Petitioner told Dr. Woods where she fell and Dr. Woods called Kenneth Carr, the Superintendent of Buildings and Grounds for the School District, to tell him

about Petitioner's fall. (Tr. 192-194). Her initial purpose was to yell at him for his crew not properly clearing the parking lot because she was upset that one of her teachers fell. (Tr. 194, 196). Dr. Woods immediately went out to look at the location where Petitioner said that she fell. (Tr. 194-195). While she was out there, she noted that the area had been plowed and salted and there was no ice. (Tr. 194-195). Her supervisor's Investigation Report also stated that "there was no ice observed on the ground in the area leading to her car that [she] observed." (Resp. Ex. 8). She testified that she expected to see ice in the area where Petitioner fell but she did not see any. (Tr. 194-195). Dr. Woods was wearing high heels and she did not find the area to be slippery. (Tr. 194). She also kicked around the area to see if she could find any slippery spots and she could not find any. (Tr. 194). Dr. Woods went back to check with Petitioner about the area that she fell and she confirmed the area again, about 5 minutes after checking it the first time. (Tr. 194) Dr. Woods again went out to that area and she did not observe any slipperiness or ice. (Tr. 194-195). Dr. Woods testified that Mr. Carr's crew had done their job and she had apologized to him for yelling at him because, after viewing the area herself, she felt that the area was sufficiently plowed and salted. (Tr. 197-198)

Respondent also presented testimony from Mr. Carr. (Tr. 164-165). He testified that his crew was out there that day plowing and salting the parking lot. (Tr. 164-165). Mr. Carr viewed the video of Petitioner's fall and he verified that his crew was seen in the video plowing part of the area. (Tr. 167). Mr. Carr testified that he went to the site where Petitioner fell approximately 15 minutes after she fell. (Tr. 175). He stated that there was no ice in the area where she fell and that the area of the parking lot in question had been salted and plowed. (Tr. 172-173, 176). Mr. Carr noted that the salt was still in the area where Petitioner said that she fell and had not melted away. (Tr. 172-173, 176). He also noted that there was a cleared area to Petitioner's right that

Petitioner could have walked over, rather than walking over the median area, which looked to still have snow on it. (Tr. 172-173). Without snow, the median area was shown to have grass in that area. (See Respondent's Ex. 2).

In relation to the parking lot, contrary to Petitioner's testimony, the parking lot where Petitioner fell was open to usage by teachers, visitors, parents, vendors, and other members of the public. Dr. Woods and Nurse Gore verified that the parking lot at issue was open to the public and not exclusive to employees. (Tr. 162, 200-201, 201-202). Dr. Woods also testified that teachers are not required to park in that lot and in fact, can park on the street. (Tr. 200-201, 201-202). Teachers can park anywhere they want, expect in areas designated for the principal, nurse, dean, and handicap parking spots. (Tr. 200-201, 201-202). Petitioner initially testified that the lot was exclusive to school personnel but then on cross-examination, when confronted with her recorded statement, she admitted that the parking lot was open to the public and that the only reason that she thinks that the parking lot is for employees only is because she has only seen employees park there, even though she works at multiple schools and she really does not know what is going on in the Yates parking lot. (Tr. 15-16, 82-83, 88-89). Furthermore, although Petitioner stated that she was directed that only teachers and staff could park in the parking lot, she could not recall who allegedly directed her that she had to park in the lot. (Tr. 15-16, 82-83, 88-89). She also could not state why she thought that teachers could not park on the street. (Tr. 15-16, 82-83, 88-89).

Petitioner's husband showed up at the school about a half an hour after her fall and he took her to the District Office where she filled out some more paperwork. (Tr. 25, 156). After completing this paperwork, her and her husband went to Ingalls Memorial Hospital Occupational Medicine at about 2:00 p.m. (Tr. 25-26); (Pet. Ex. 1, Bates No. 00367). She complained of pain

in the back of her head, her neck, and her left thigh. (Pet. Ex. 1, Bates No. 00369). Petitioner was placed on restricted duty at that time and prescribed brain rest. (Pet. Ex. 1, Bates No. 00388). She was told to return on March 7, 2014.

Petitioner instead returned to Ingalls Occupational Medicine on March 6, 2014, and a head CT was performed, which was found to be normal. (Pet. Ex. 1, Bates No. 00384, 00388); (Resp. Ex. 7). On that day, Ingalls Occupational Medicine advised that Petitioner could return to work at full duty on March 10, 2014. (Pet. Ex. 1, Bates No. 00385). Despite this return to work, Petitioner failed to return to work after her primary care physician, who is not a specialist, kept her off of work. (Pet. Ex. 1, Bates No. 00381); (Tr. 92). Despite this return to work full-duty by Ingalls Occupational Medicine, Petitioner testified that no doctor ever returned her to work full duty.

Petitioner then saw Dr. Cressa Perish, without any referral from Occupational Medicine, on March 7, 2014, and she told Dr. Perish that she "may have slipped on some ice." (Pet. Ex. 2, Bates No. 00478). Petitioner told Dr. Perish that she lost consciousness for less than a minute. (Pet. Ex. 2, Bates No. 00476). Dr. Perish noted that the head CT on the March 6, 2014, was unremarkable but she nonetheless instructed Petitioner to stay off of work for another week pending follow-up. (Pet. Ex. 2, Bates No. 00476 and 00478).

Petitioner was seen again at Occupational Medicine on March 12, 2014. (Pet. Ex. 1, Bates No. 00379). Based on Dr. Perish keeping Petitioner off of work, Petitioner was released to restrictive duty and told not to engage in any complex tasks or rapid head movements. (Pet. Ex. 1, Bates No. 00379). Petitioner reported feeling feels light headed at times and having headaches. (Pet. Ex. 1, Bates No. 00380).

Two days later, she went to see Dr. Perish again. (Pet. Ex. 2, Bates No. 00473). She complained of sharp pains in her head and some cognitive function issues with occasional slurred speech and occasional vertigo. (Pet. Ex. 2, Bates No. 00473). Dr. Perish prescribed Tylenol and told her not to work or drive and to follow up in two weeks. (Pet. Ex. 2, Bates No. 00475). Dr. Perish noted that her attention span and concentration were normal. (Pet. Ex. 2, Bates No. 00476).

On March 19, 2014, she followed up with Ingalls Occupational Health and her restricted duty was continued. (Pet. Ex. 1, Bates No. 00374). She was referred to Dr. McManus.[1] (Pet. Ex. 1, Bates No. 00374). She also reported pain in her head and scalp, which was intermittent in nature and she stated that she was having intermittent headaches and shaking "nervous" hands. (Pet. Ex. 1, Bates No. 00375). On examination, there was no evidence of edema or swelling although some left-sided head tenderness was noted. (Pet. Ex. 1, Bates No. 00376). The doctor noted that Petitioner had not returned to work on the advice of Dr. Perish. (Pet. Ex. 1, Bates No. 00376). The notes reflected that Petitioner did not want to do light duty because she did not feel that she could perform said light duty even though the light duty only entailed brain rest and simple task work. (Pet. Ex. 1, Bates No. 00376). She was instructed to return immediately if she experienced any dizziness, numbness, tingling, vision changes, or nausea/vomiting. (Pet. Ex. 1, Bates No. 00377).

On March 28, 2014, Petitioner returned to Dr. Perish for follow-up on head discomfort, which Petitioner reported was getting better. (Pet. Ex. 2, Bates No. 00470). She reported occasional slurred speech and an off-balance feeling with a transient and mild headaches if she turns her neck suddenly. (Pet. Ex. 2, Bates No. 00470). Dr. Perish noted that Petitioner reported

[1] Both parties requested medical records from Dr. McManus and the doctor's office failed to comply with the subpoenas.

"no noted cognitive deficits." (Pet. Ex. 2, Bates No. 00470). Despite these improvements, Dr. Perish prescribed speech, physical, and occupational therapy to Petitioner. (Pet. Ex. 2, Bates No. 00472).

On April 8, 2014, Petitioner saw Dr. Perish, who told her not to work until she followed-up with her on May 9, 2014. (Pet. Ex. 2, Bates No. 00469). Dr. Perish advised her to follow-up with a neurologist and neuropsychologist within a month. (Pet. Ex. 2, Bates No. 00469). At this appointment, which was over a month post-accident, Petitioner reported new symptoms of nervousness, lack of coordination, and intention tremors as well as trouble tracking prolonged conversations. (Pet. Ex. 2, Bates No. 00467).

Petitioner went to the emergency room at Ingalls on April 18, 2014. (Pet. Ex. 1) She reported headaches with a pain level of 8 out of 10 plus dizziness. (Pet. Ex 1, 00015). She told the emergency rooms doctors and staff that she felt these symptoms since her fall on March 5, 2014. (Pet. Ex 1, 00015). At trial, she testified that she had "stroke-like" symptoms. (Tr. 33). A repeat brain CT was done and it was compared the brain CT on March 6, 2014. (Pet. Ex. 1, Bates No. 00015);(Resp. Ex. 5). Again, the CT scan was normal. (Pet. Ex. 1, Bates No. 00015-00016). She also had another CT of the neck which again, was unremarkable. (Pet. Ex. 1, Bates No. 00016);(Resp. Ex. 5). At the ER on April 18, 2014, it was noted that her gait steady. (Pet. Ex. 1, Bates No. 00020).

Petitioner then treated with Dr. Engin Yilmaz on April 22, 2014. (Pet. Ex. 3, Bates No. 00480). Dr. Yilmaz found that Petitioner might have mild suboccipital neuralgia and that his might be causing some of her symptoms. (Pet. Ex. 3, Bates No. 00480).

Petitioner followed up again with Dr. Perish on May 9, 2014. (Pet. Ex. 2, Bates No. 00464). At this appointment, Dr. Perish admonished Petitioner because she failed to follow up

with both Dr. Yilmaz and Dr. McManus and Dr. Perish said that she could not justify further leaves of absence if Petitioner did not follow-up with these doctors in a timely manner. (Pet. Ex. 2, Bates No. 00464).

She again followed up with Dr. Yilmaz on May 23, 2014. (Pet. Ex. 8, Bates No. 00577-00578). Dr. Yilmaz recommended that she go have a neuropsychologic evaluation which way be helpful in evaluating cognitive or psychological components of her complaints. (Pet. Ex. 8, Bates No. 00578). He also found that she may have cervical neuralgia in additional possible post-concussion syndrome. (Pet. Ex. 8, Bates No. 00578).

Dr. Perish saw Petitioner again on May 27, 2014. (Pet. Ex. 7, Bates No. 00552). Petitioner told Dr. Perish that her neurologist that that her headaches and neck pain might be the result of a pinched nerve. (Pet. Ex. 7, Bates No. 00552). Petitioner was to follow-up in a month and Dr. Perish continued to keep her off of work. (Pet. Ex. 7, Bates No. 00554).

On June 22, 2014, Petitioner again reported to the Ingalls ER complaining of a painful cough for over 2 weeks with a 98.2 temperature. (Pet. Ex. 1, Bates No. 00199, 00204). This is contrary to her testimony that she went to the ER because she "was having the same symptoms. [Her} head was hurting really, really bad, [her] hand felt numb, and [she] became very confused, not knowing where [she] was." (Tr. 40-41). On examination, her head was found to be atraumatic. (Pet. Ex. 1, Bates No. 00207)

She again went to Ingalls ER on July 1, 2014. (Pet. Ex. 1, Bates No. 00357). She complained of a lump under her right arm yet, during the trial, she testified that she went to the ER because of her head symptoms from the fall. (Pet. Ex. 1, Bates No. 00359); (Tr. 44). Her temperature was normal and she was discharged that same day. (Pet. Ex. 1, Bates No. 00359). She returned again on July 7, 2014. (Pet. Ex. 1, Bates No. 00211). This time she reported to the

ER with a 102 degree fever, yet at the trial, she testified that she complained of head and neck pain. (Pet. Ex. 1, Bates No. 00211) (Tr. 47). She also reported swelling under her right arm but she denied any headaches. (Pet. Ex. 1, Bates No. 00222).

Even though Petitioner did not see Dr. Perish from May 27, 2014, through July 16, 2014, Dr. Perish kept giving Petitioner off work slips. (Pet. Ex. 2, Bates No. 00441-00445; Pet. Ex. 7, Bates No. 00542). Dr. Perish saw Petitioner after her emergency room stay for her febrile illness. (Pet. Ex. 7, Bates No. 00542). Dr. Perish renewed Petitioner's prescription for physical, occupational, and speech therapy for 12 more visits and she noted that Petitioner was to follow up with Dr. Yilmaz as well as an eye doctor. (Pet. Ex. 7, Bates No. 00542).

Petitioner followed up with Dr. Perish again on August 1, 2014. (Pet. Ex. 7, Bates No. 00538). Dr. Perish noted that Petitioner continued to make the same complaints of blurred vision, left sided neck pain, and leftward listing on walking. (Pet. Ex. 7, Bates No. 00538). Dr. Perish noted that Petitioner reported no sustained improvement in her symptoms. (Pet. Ex. 7, Bates No. 00538). Dr. Perish noted that Petitioner "has been seeing Dr. Yilmaz who spoke to me recently and requests a second opinion neurologist evaluation at a university setting since [patient's symptoms] are not consistent with exams or typical neurologic patterns." (Pet. Ex. 7, Bates No. 00538). Petitioner was also supposed to see Dr. Tim McMannus on August 8, 2014, for a cognitive evaluation and Dr. McMannus told Dr. Perish that he would contact her if patient does not attend this appointment. (Pet. Ex. 7, Bates No. 00538). Dr. Perish continued to keep Petitioner off of work and she ordered a walker for Petitioner to be trained with at physical therapy. (Pet. Ex. 7, Bates No. 00541).

On August 27, 2014, Petitioner treated with Dr. Jeffery Nichols related to her headache and vision problems. (Pet. Ex. 4, Bates No. 00483 - 00485). Overall, the examination with Dr.

Nichols was normal, despite Petitioner's complaints of pain and migraines that she related to her March, 2014, accident. (Pet. Ex. 4, Bates No. 00485). Dr. Nichols instructed her to follow-up in three months, if needed. (Pet. Ex. 4, Bates No. 00485).

On August 28, 2014, Petitioner again saw Dr. Perish. (Pet. Ex. 7, Bates No. 00534). Dr. Perish noted that Petitioner was going to follow up with Dr. Kelly Thomas for a second neurological opinion and that Petitioner had already seen and treated with Dr. McMannus for a neuro-psych evaluation and he found the examination to be highly suggestive for magnification of symptoms and he "did not find anything attributable to head injury." (Pet. Ex. 7, Bates No. 00534). Dr. Perish noted on physical examination that Petitioner walked with a left sided gait when she observed her but Dr. Perish's staff noted that Petitioner had no gait difficulty when she walked to the bathroom in the waiting room and that she did not appear to require the assistance of the walker until she made eye contact with Dr. Perish's staff, which is when she began to veer to the left again. (Pet. Ex. 7, Bates No. 00536). The Arbitrator noted similar behavior at the hearing site. The Petitioner walked very quickly with the walker until she got close to the hearing room, then proceeded at a very slow pace. IN any event, Dr. Perish continued to keep Petitioner off of work and she referred Petitioner to Dr. Kelly Thomas for a second neurological opinion. (Pet. Ex. 7, Bates No. 00536). Dr. Perish continues to keep Petitioner off of work. (Pet. Ex. 7, Bates No. 00536).

Petitioner followed up with Dr. Perish on September 3, 2014, and she complained of feeling faint while she was at a Subway restaurant. (Pet. Ex. 7, Bates No. 00529). Of particular note are Dr. Perish's observations that Petitioner's report of symptoms including tingling and jitteriness increased from about 1 to 4 minutes in duration to about 15 minutes in duration after her husband enter the exam room. (Pet. Ex. 7, Bates No. 00529). Dr. Perish also noted that

Petitioner "was again observed by my staff to walk normally to our reception desk, complete paperwork and begin to walk back to her seat when her husband reportedly arrived and intercepted her, said "No, no," and grasped her arm and she then began to walk in a leftward listing manner again." (Pet. Ex. 7, Bates No. 00529).

Petitioner began treating with Dr. Elizabeth Pieroth on September 12, 2014. (Pet. Ex. 5). Dr. Pieroth noted that Petitioner was reporting a fall with loss of consciousness that was not witnessed. (Pet. Ex. 5). Dr. Pieroth explained to Petitioner that at 6 months post injury, her symptoms are not due to her concussion but may be secondary to other injuries. (Pet. Ex. 5). She recommended that Petitioner return to her primary care physician to explore other causes. (Pet. Ex. 5).

On September 29, 2014, Petitioner followed up with Dr. Perish. (Pet. Ex. 7, Bates No. 00517). Dr. Perish noted that Petitioner's repeated complaints regarding left sided neck pain, cheek twitching, and left lip numbness should be reported to the neurologist, which Dr. Perish had repeatedly explained to Petitioner. (Pet. Ex. 7, Bates No. 00517). Dr. Perish also noted that Petitioner was now interested in having a complete copy of her medical records for her own perusal...not for her attorney or other doctor. (Pet. Ex. 7, Bates No. 00517). She further noted that Petitioner was speaking very lucidly and appeared very coordinated in replacing her shoes after Dr. Perish examined her feet. (Pet. Ex. 7, Bates No. 00517). Dr. Perish noted that Petitioner was supposed to follow-up with her new neurologist in two weeks and report back to Dr. Perish in two months. (Pet. Ex. 7, Bates No. 00520).

On October 3, 2014, Petitioner saw a new doctor, Dr. Lance Wallace, seemingly without a referral from any of her treating physicians. (Pet. Ex. 9, Bates No. 00584). She again reported the same symptoms that she had reported to her other doctors. (Pet. Ex. 9, Bates No. 00584). Dr.

Wallace noted that he wanted a repeat MRI and that he would speak with a neurologist about her condition. He instructed her to continue with physical therapy. (Pet. Ex. 9, Bates No. 00586). He diagnosed her with vestibular dysfunction, neurologic gait dysfunction, and post-concussion syndrome. (Pet. Ex. 9, Bates No. 00587). Dr. Wallace wrote Petitioner a work status keeping her off of work until December 2, 2014. (Pet. Ex. 9, Bates No. 00588).

On October 14, 2014, Petitioner had another MRI of her brain both with and without contrast. (Pet. Ex. 6, Bates No. 0513); (Resp. Ex. 6). Again, this test was unremarkable. She also had a MRI of her cervical spine on September 27, 2014, six and a half months post accident, which showed a small central disc protrusion at C3-C4 and a tiny central protrusion at C4-C5. (Pet. Ex. 6, Bates No. 00507); (Resp. Ex. 6). No physicians have linked these cervical issues to Petitioner's fall on March 5, 2014.

At trial, Petitioner testified clearly. She did not display any signs of cognitive difficulties or memory issues. Her speech was not slurred. She did not appear to be in a physical pain. She arrived to the hearing room using a walker, but it is not clear from the record who prescribed it to her. There is no doctor's prescription for a walker in the medical records.

II. CONCLUSIONS OF LAW

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

An employee's injury is compensable under the Workers' Compensation Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (West 2006). Both elements must be present at the time of the claimant's injury in order to justify compensation. *Illinois Bell Telephone Co. v. Industrial Comm'n*, 131 Ill.2d 478, 483, 546 N.E.2d 603 (1989). Arising out of the employment refers to the origin or cause of the claimant's injury. An injury arises out of the

employment if the petitioner was exposed to a risk of harm beyond that to which the general public is exposed. *Brady v. L. Ruffolo & Sons Construction Co.*, 143 Ill.2d 542, 548, 578 N.E.2d 921 (1991). As the supreme court held in *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill.2d 52, 58, 541 N.E.2d 665 (1989):

> For an injury to 'arise out of' the 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. [Citations.] Typically, an injury arises out of one's employment if, at the time of the occurrence, the employee was performing acts he was instructed to perform by his employer, acts which he 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. [Citation.] 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. [Citations.]

"In the course of the employment" refers to the time, place, and circumstances under which the claimant is injured. *Scheffler Greenhouses, Inc. v. Industrial Comm'n*, 66 Ill.2d 361, 366, 362 N.E.2d 325 (1977). In general, injuries sustained at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work, or within a reasonable time before and after work, are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill.2d at 57, 541 N.E.2d 665; *Wise v. Industrial Comm'n*, 54 Ill.2d 138, 142, 295 N.E.2d 459 (1973).

In this case, the question is whether Petitioner sustained an injury that arose out of and in the course of her employment. Petitioner testified that when she fell, she was on her way to lunch, then she was going to go to a meeting with a teacher at Seiden then to a meeting at the District Office, which was scheduled for 2:00 p.m. Petitioner, a literacy coach, occasionally travelled between school buildings and the District Office. The majority of the time, Petitioner would work at one school for the entire day. Sometimes, typically on Fridays, Petitioner

reported to meetings at the District Office. On other limited occasions, Petitioner would leave the school that she was assigned to for that day to do work with teachers at other schools but according to Dr. Woods, Petitioner was required to inform her when Petitioner needed to leave Yates to work at another school in the District. Petitioner's statements that she could leave Yates school whenever she wanted to despite being scheduled to work at that school for that day is simply not credible. If Petitioner was really on her way to Seiden as she testified, there was no one to corroborate this meeting and this alleged meeting was occurring outside of the normal protocol or procedure of how these meetings are scheduled or made.

On March 5, 2014, Petitioner fell in the area of the Yates parking lot at or about 12:00 p.m. Petitioner testified that she planned to eat her lunch in the car after going to pick it up from a location about ten to fifteen minutes away. While there is no record of this alleged meeting with the teacher at Seiden, assuming that said meeting was really scheduled, the close proximity of Seiden School to the District Office would have only required Petitioner to be at Seiden by 1:00 p.m. or so to have her 40 minute meeting with the teacher there and to make the 2:00 p.m. meeting at the District Office. Petitioner did not have to leave at noon if she truly was intending to eat her lunch in the car on the way to Seiden. Petitioner had about a two-hour window to complete her alleged 40 minute meeting with the teacher at Seiden and then to commute from Seiden to the District Office. If Petitioner arrived at the Seiden by 1 p.m., she would have had plenty of time to make her meeting at the District Office. The timing simply doesn't fit.

The parties also submitted some video of Petitioner's fall which shows Petitioner walking at a normal to fast pace and then falling on an area that appears to be a median separating the parking lot from a driveway or street. After her fall, Petitioner gets right up and continues to walk to at a normal pace. Contrary to Petitioner's assertions at the trial that the parking lot was

open to the public, the overwhelming testimony was that the parking lot where Petitioner fell was open to the public. This lot was not exclusive to teachers and it could be used by teachers, parents, vendors, or other visitors and guests of Yates school. Petitioner's statements that the parking lot was only for the use of the teachers are not credible. Teachers can park wherever they want, including on the street, with the sole exception of parking in spots designated for the principal, the school nurse, the school dean, and the handicap parking spots. The evidence shows that Petitioner was not required to park where she parked and that lot was not exclusive to teachers.

Because the parking lot is open to the public, Petitioner was exposed to the same risk of fall to which the general public was exposed. Also, she was on her way to lunch, not to a meeting or other work function. Therefore, the Petitioner's accident did not arise out of or in the course of her employment.

Petitioner has argued that she was a traveling employee but this argument fails because at the time that Petitioner was injured, she was not a traveling employee. For an employee to be considered a traveling employee, the employee must be required to travel away from his employer's premises in order to perform his job. *Jensen v. Industrial Comm'n*, 305 Ill.App.3d 274, 278, 711 N.E.2d 1129 (1999). "Under a traveling employee analysis, determination of whether an injury arose out of and in the course of the employee's employment depends on the reasonableness of the employee's conduct at the time of the injury and whether the employer could anticipate or foresee the employee's conduct or activity." *Insulated Panel Company v. Industrial Commission, et al.* 318 Ill.App.3d 100, 102-103, 743 N.E.2d 1038 (2nd Dist., 2001) citing *Johnson v. Industrial Comm'n,* 278 Ill.App.3d 59, 64 (3rd Dist., 1996). Traveling employees may be compensated for injuries incurred while performing an act they were not

specifically instructed to perform however, the act must have arisen out of and in the course of his employment. *Venture-Newberg-Perini, Stone & Webster, v. Illinois Workers' Compensation Commission,* 2013 IL 115728, ¶ 18, 1 N.E.3d 535, 540 (2013). To make this determination, the court considers the reasonableness of the act and whether it might have reasonably been foreseen by the employer. Id.

In this case, Petitioner does not fit the category of a traveling employee. First, the day that she was injured she was assigned to work at Yates school. Without seeking the permission of her supervisor at that school, Dr. Woods, Petitioner left the school to go to lunch and then allegedly, to a meeting with a teacher at another school. On a normal day, Petitioner would be allowed to leave the school grounds to go to lunch, if she wanted to, but she would have to inform Dr. Woods that she was needed at another school that day. Petitioner failed to notify Dr. Woods she was allegedly needed at Seiden and there is no record, except her own self-serving statements, that she actually had a meeting scheduled at Seiden school. Even if she did have such a meeting, she did not have to be at Seiden until 1:00 p.m. in order to make her meeting at the District Office at 2:00 p.m. Petitioner's off schedule meeting, of which there is no record, does not place Petitioner in the category of traveling employee, particularly since it was not at all foreseeable that Petitioner would leave school grounds for an unknown, unscheduled, and unapproved meeting. Petitioner's act of allegedly scheduling and going to a meeting that no one knew about and without notifying Dr. Woods, which is the usual procedure, was not reasonable or foreseeable. Petitioner was not a traveling employee and therefore, this exception does not apply. Petitioner's accident thus did not arise out of and was not in the course of her employment and is not compensable.

Additionally, in order to trier of fact to conclude that the Petitioner is traveling employee, one must give the Petitioner the benefit of the doubt of whether she was on her way to a meeting at Seiden and then later, to another meeting at 2 o'clock. None of those assertions were corroborated by a third party. The e-mails Petitioner introduced into evidence do nothing to buttress her claim of continuing to work that day and in fact, on close inspection, create more doubt. Petitioner could just as well have been returning home that day. Additionally, there is no reason to give the Petitioner the benefit of the doubt about this issue, when her credibility was damaged on so many others. For instance, it seems clear that the Petitioner was never directed to park in that lot, nor was that lot private. Petitioner's credibility was damaged when she testified that she could come and go between the schools as she pleased, but her principal stated otherwise. Her credibility was damaged when she stated that she lost consciousness immediately after the fall. Her credibility was questioned when she stated that no doctor ever returned her to work. It was again questioned when she stated that she went to the ER for symptoms related to the fall, instead of a fever. More importantly, her doctors do not support her claim and more than one of them suspect symptom magnification. Finally, no doctor prescribed the walker the Petitioner used in court.

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

The Arbitrator incorporates and adopts the findings contained within Section (C) of this decision. Respondent disputes that Petitioner's current need for medical treatment is related to her March 5, 2014, injury, but even if it is, this accident is not compensable. The Arbitrator agrees with Respondent's assessment and finds that the Petitioner's current need for further medical treatment, as well as some of her previous medical treatment after her initial release to

full duty on March 10, 2014, was not related to the March 5, 2014, accident. Her March 5, 2014, accident resulted in a need for minor treatment but her continued treatment was excessive and has been eventually deemed by own treating physicians as excessive.

Initially, Petitioner's symptoms may have been related to her fall on March 5, 2014, but as for March 10, 2014, she was returned to work by Ingalls Occupational Medicine. (See Pet. Ex. 1, Bates Stamped No. 00385). Despite this full duty release, Dr. Perish, a primary care physician and not a head or brain specialist, kept Petitioner off of work based upon Petitioner's subjective complaints and some of the symptoms that she was exhibiting. Eventually, Dr. Perish, as well as Petitioner's other treating physicians, began to suspect that Petitioner was exaggerating, malingering, and even faking, her symptoms. This is evidenced by the following treatment notes:

1. August 1, 2014 – Dr. Perish that Petitioner showed no improvement in her symptoms and that Petitioner "has been seeing Dr. Yilmaz who spoke to me recently and requests a second opinion neurologist evaluation at a university setting since [patient's symptoms] are not consistent with exams or typical neurologic patterns." (Pet. Ex. 7, Bates No. 00538 - 00541). Dr. Perish noted that Petitioner was supposed to see Dr. Tim McMannus on August 8, 2014, for a cognitive evaluation and Dr. McMannus told Dr. Perish that he would contact her if patient does not attend this appointment. (Pet. Ex. 7, Bates No. 00538 - 00541).

2. August 27, 2014 – Petitioner treated with Dr. Jeffery Nichols related to her headache and vision problems and he found her examination to be normal, despite her complaints of pain and migraines. Dr. Nichols instructed her to follow-up in three months, if needed. (Pet. Ex. 4, Bates No. 00485).

3. August 28, 2014 - Dr. Perish noted that Petitioner was going to follow up with Dr. Kelly Thomas for a second neurological opinion and that Petitioner had already seen and treated with Dr. McMannus for a neuro-psych evaluation. Dr. Perish noted that Dr. McMannus informed her that he found Petitioner's examination to be highly suggestive for magnification of symptoms and he "did not find anything attributable to head injury." (Pet. Ex. 7, Bates No. 00534). Dr. Perish also noted that Petitioner walked with a left sided gait but when she was observed Dr. Perish's staff, they noted that Petitioner had no gait difficulty and that she did not appear to require the assistance of the walker until she made eye contact with Dr. Perish's staff, which is when she began to veer to the left again. (Pet. Ex. 7, Bates No. 00536).

4. September 3, 2014 – Petitioner treated again with Dr. Perish, who observed that Petitioner's report of symptoms including tingling and jitteriness increased from about 1 to 4 minutes in duration to about 15 minutes in duration after her husband enter the exam room and that Dr. Perish also noted that Petitioner "was again observed by my staff to walk normally to our reception desk, complete paperwork and begin to walk back to her seat when her husband reportedly arrived and intercepted her, said "No, no," and grasped her arm and she then began to walk in a leftward listing manner again." (Pet. Ex. 7, Bates No. 00529).

5. September 12, 2014 – Dr. Pieroth explained to Petitioner that at 6 months post injury, her symptoms are not due to her concussion but may be secondary to other injuries and she recommended that Petitioner return to her primary care physician to explore other causes. (Pet. Ex. 5).

6. September 29, 2014 – Dr. Perish noted that Petitioner kept making complaints that Dr. Perish repeatedly told her should be directed to her neurologist. She also was speaking very lucidly and appeared very coordinated in replacing her shoes after Dr. Perish examined her feet. Petitioner also requested to review her medical records. (Pet. Ex. 7, Bates No. 00517).

7. October 3, 2014 – Petitioner now sought treatment with Dr. Wallace seemingly after reviewing her medical records on September 19, 2014.

All of these notes and observations by Petitioner's treating doctors illuminate Petitioner's symptom magnification and malingering. Because of the above, the Arbitrator hereby finds that Petitioner's treatment should have ended on March 10, 2014, when she was returned to full duty by Ingalls Occupational Medicine. However, since Petitioner's injury was not in the course of her employment and it did not arise out of her employment and further, since she was not a traveling employee, Petitioner's injuries are not causally connected to her fall on March 5, 2014.

J. Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary charges?

The Arbitrator incorporates and adopts the findings contained within Sections (C) and (F) of this decision. The Arbitrator finds that since Petitioner's injury is not compensable, her treatment therefore was not reasonable and necessary and does not need to be paid for by Respondent. If the injury were compensable, the only dates of treatment that would be

reasonable would be the treatment received from March 5, 2014, through March 10, 2014, but alas, the injury is not compensable. Respondent is not liable for any medical bills or treatment and no medical is awarded.

K. Is Petitioner entitled to any prospective medical care?

The Arbitrator incorporates and adopts the findings contained within Sections (C), (F), and (J) of this decision. The Arbitrator finds that the Petitioner is not entitled to any prospective medical care. This is not a compensable injury and even if it was, Petitioner's treatment should have ended on March 10, 2014. For the above reasons, the Arbitrator denies Petitioner's claim for prospective medical care.

L. What temporary benefits are in dispute?

There is a dispute regarding temporary benefits not being paid since March 6, 2014. Respondent denied this claim by arguing that the Petitioner's accident did not arise out of and was not in the course of her employment. The Arbitrator agrees with this assessment and hereby denies any prospective medical treatment.

M. Should penalties and fees be imposed?

The Arbitrator finds that penalties and fees should not be awarded because Respondent has acted in good faith both when it denied Petitioner's claim for workers' compensation benefits and further, for medical treatment and temporary total disability benefits. Respondent's denial of this claim was reasonable and not vexatious and therefore, Petitioner's motion for penalties and fees is hereby denied. .

N. Is Respondent due any credit?

The Arbitrator finds that Petitioner's claim was properly denied. However, if the claim was compensable, Respondent would be entitled to a credit under Section 8(j) for any and all medical bills paid by it group insurance carrier.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Melvin Pardieck,
Petitioner,

vs.

Midcoast Aviation,
Respondent.

15IWCC0650

NO: 12 WC 17417

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 7, 2014, is hereby affirmed and adopted.

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

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

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

DATED: AUG 21 2015
O8/4/15
RWW/rm
046

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0650

PARDIECK, MELVIN
Employee/Petitioner

Case# 12WC017417

MIDCOAST AVIATION
Employer/Respondent

On 10/7/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0810 BECKER PAULSON & HOERNER PC
ROD THOMPSON
5111 W MAIN ST
BELLEVILLE, IL 62226

1256 HOLTKAMP LIESE ET AL
KENT SCHULTZ
217 N 10TH ST SUITE 400
ST LOUIS, MO 63101

15IWCC0650

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Melvin Pardieck
Employee/Petitioner

v.

Midcoast Aviation
Employer/Respondent

Case # 12 WC 017417

Consolidated cases: N/A

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **8/21/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0650

FINDINGS

On **11/23/09**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 $**46,290.40**; the average weekly wage was $**890.20**.

On the date of accident, Petitioner was **46** years of age, ***single*** with **0** dependent children.

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

Respondent ***has*** 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

Petitioner failed his burden of proof that he sustained an accident/occupational disease arising out of and in the course of his employment, and failed to establish that his employment was the causative factor for his condition of ill-being. Therefore, compensation is denied.

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

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

Signature of Arbitrator

9/29/14
Date

OCT 7- 2014

Melvin Pardieck v. Midcoast Aviation
12 WC 017417

15IWCC0650

The Arbitrator finds the following facts:

Petitioner 51 years of age, 5'9" tall, weighing 215 pounds, was employed by the Respondent as an aircraft painter from 2001 until he was laid off in October, 2009. His title was Aircraft Painter 3, and his job consisted of stripping, sanding, priming and painting, privately owned jets. He would wear protective clothing and devices and his job involved climbing ladders, crawling on hands and knees, getting underneath and all over the jet. He would spend two thirds of the time standing, reaching, climbing, stooping, kneeling, crouching or crawling. He would lift ten pounds one third to two thirds of the time, twenty five pounds one third to two thirds of the time and fifty pounds less than one third of the time.

He has had problems with his right hip dating back to a prank at work in around 2006 when a co-worker pulled out a chair from underneath him. He has had right hip pain ever since, self treated with over the counter medications, without relief. He did not seek treatment until 2009, two days before his layoff from work.

He first sought treatment with his primary care physician, Dr. Lebeau, on October 14, 2009. Prior to that date he had treated with Dr. Lebeau for a variety of conditions including diabetes and obesity. His weight had consistently been over three hundred pounds for multiple years, and Dr. Lebeau had recommended a weight loss program.

At the October 14, 2009 visit, he complained of worsening right hip pain with standing or walking. Ultram was prescribed and he returned on October 20, 2009. At that visit he reported to Dr. Lebeau his layoff, his insurance running out, and requested an orthopedic referral as soon as possible. Dr. Lebeau referred him to Dr. Morton of Orthopedic & Sports Medicine Physicians, and he initially saw him on October 30, 2009.

He reported to Dr. Morton the prank incident and right hip pain that has gotten progressively worse. Dr. Morton had x-rays done which showed end-stage osteoarthritic changes, bone-on-bone collapse, and recommended a hip replacement. He referred him to Dr. Nunley at Washington University orthopedics, who specializes in hip and knee surgery.

He first saw Dr. Nunley on November 23, 2009, giving a history of right hip pain starting with a prank at work and has just kept getting worse. He treated the pain with Ultram without relief. He had a significant increase in pain over the last several months, and also reported recent weight gain of 25 pounds. Additional history of his recent layoff, and prior to this he was an airplane painter. He had pain at work as well as pain with activities of daily living. Over the last three weeks had increased his alcohol intake and had findings of jaundice. Dr. Nunley recommended a total hip replacement but first that he stop drinking and lose weight.

He returned to Dr. Nunley on February 1, 2010 reporting that he had stopped drinking and had lost 25 pounds. Dr. Nunley scheduled him for surgery and it was done on March 5, 2010, consisting of a right total hip arthroplasty.

The treatment records do not include any statements disabling the Petitioner from work but Dr. Nunley testified in his deposition that his protocol is to take his patients off any work the day of surgery. When Petitioner was seen for the final post-op follow up visit on October 18, 2010, he reported to Dr. Nunely that he was anxious to get back to work and wanted to go to work for a barge doing heavy lifting labor work. Dr. Nunely released him to full work including high intensity manual labor, but testified in his deposition that if he had seen him twelve weeks after surgery (i.e., May 27, 2010) he likely would have released him to full duty

work at that time, as he typically would release someone to full duty, full demand level, 12 weeks post total hip replacement.

At the October 18, 2010 final visit, it is reported that overall Petitioner is doing extremely well. No pain. No problems. No limp. Unlimited in distance. Normal stair climbing. Able to put on shoes and socks easily. He had a negative clinical exam and x-rays showed excellent component position.

At the Hearing, Petitioner testified that he had no additional treatment since he was released by Dr. Nunley. He had a slight limp and occasional pain and stiffness. He did not yet have full movement and used a railing for climbing stairs, and was real slow in sitting down. He was not taking any medications other than Hydrocodone for his right shoulder and back. He has not worked since 2009 but the Petitioner is not claiming he is unable to work due to his right hip. He applied for and received unemployment compensation for two years after he was laid off on October 16, 2009, and received unemployment compensation during the period of time leading up to and after the surgery on March 5, 2010.

The deposition of Dr. Nunley was admitted on behalf of Petitioner. He testified on direct exam that patients who have an injury, work related or at home, can cause internal damage to the joint that causes it to no longer perform at the same level, causes an accelerated wear pattern, and then certain activities that are higher demand, just like each of us if we were to do high demand activities, puts more wear and tear on the joints. He further testified that people who work in a high demand activity job or patients who do sports, extreme type sports, put more wear and tear on the joint so it accelerates the degenerative process. Based upon this reasoning and the hypothetical question asked by Petitioner's attorney, he testified that Petitioner's work activities as a painter after his original fall in 2006, might have or could have been a cause or one of the causes of the condition of ill being for which he treated. (Petitioner's Exhibit 5, pages 17-21).

On cross examination, however, he admitted that obesity can be a causative factor for the type of joint disease that he saw in the Petitioner's right hip. The Petitioner reported to him when he initially saw him a recent weight gain of 25 pounds, and weight gain of that nature could symptomatically aggravate the underlying degenerative joint disease that he found in him. (Petitioner's Exhibit 5, page 25). He testified that the employment activities included in the hypothetical question may or could have been one of the many contributing aggravating factors of his degenerative joint disease, and it is just as true and correct that the incident of 2006 when he initially hurt his hip, may or could have been the cause and sole cause of the degenerative joint disease that he diagnosed and treated. This would also be true as to the natural progression of the degenerative joint disease dating back to the 2006 incident. He further testified that the obesity was a contributing cause, and that pain is multifactural, and one can have it with sitting and with certain activities. Pain is a generation of more degeneration so just being active, walking, can cause further aggravation. Any kind of activity, at home or at work, can cause aggravation, and there is no way to distinguish how much of a contributing cause is activity at work versus activity away from work. He further testified and admitted that it is just as likely that his other activities, activities of daily living and his obesity, may or could have been the aggravating common contributing factors to the degenerative joint disease that he diagnosed and treated. (Petitioner's Exhibit 5, pages 25-27).

The Respondent offered into evidence the deposition of its IME physician, Dr. James Burke. He, like Dr. Nunley, is a board certified orthopedist, specializing in treatment of the hips and knees, and has done a significant amount of joint reconstructions and hip replacements over the years of his practice. He testified that the Petitioner presented with a severely arthritic hip, severe osteoarthritis with complete loss of the joint space and spurring off the femoral head, of longstanding duration. He opined that the cause is a natural history of a congenital defect known as cam impingement in the hip, as well as obesity. (Respondent's Exhibit 1, pages 13, 14). He did not believe that the prank incident in 2006 nor Petitioner's job related activities were a causative contributing factor. (Respondent's Exhibit 1, page 16).

He explained that cam impingement is a formation of a spur and when the femoral head, the ball of the ball and socket, rubs on the edge of the socket it causes arthritis, especially when carrying around significant weight. The heavier you are is exponentially bad on the joint. (Respondent's Exhibit 1, pages 16, 17). It gives you a bigger spur which causes the joint to wear down. It starts a natural history of degeneration in the joint, breaking down the cartilage lining of the acetabul starting at the rim. That cartilage is what keeps you pain free. (Respondent's Exhibit 1, page 25).

On cross-examination he was asked that given his weight and giving his job activities, might have or could have those activities have caused an increase in his symptoms that he experienced as a result of the cam impingement. He answered not any more than normal activities of life. He was at an equal risk to have increased pain with his normal activities as he was at work. (Respondent's Exhibit 1, page 41).

Therefore the Arbitrator concludes:

1. Petitioner failed to meet his burden of proof that he sustained an accident/occupational disease arising out of and in the course of his employment which caused his condition of ill being, consisting of a severely osteoarthritic right hip. By his own admission, his symptoms began in 2006 following a prank incident at work, and were continuing and unrelenting up until the time that he initially sought treatment in October, 2009. It is worth noting that it was not until he was being laid off by the Respondent that he sought medical treatment for the first time, and reported to the medical providers significant increase in symptoms which was contemporaneous with recent significant weight gain. When he did seek treatment, he made no mention of his work related activities to his primary care physician (Dr. Lebeau), and the orthopedist that his primary care physician referred him to (Dr. Morton). The only history that he did report was right hip pain dating back to a prank incident in 2006. The only medical opinion presented by Petitioner supporting his claim, is the testimony of Dr. Nunley, the treating surgeon. The gist and ultimate opinion given by Dr. Nunley is that it was just as likely, just as true and correct, that the prank incident in 2006, the natural progression of the disease, and/or obesity, was the cause, contributing and aggravating factor of his condition of ill-being. This admission coupled with the testimony of Dr. Burke that Petitioner's work related activities was neither the cause nor contributing cause to the degenerative arthritic condition of his right hip, can lead to only one conclusion. That is, the Petitioner failed to meet his burden of proof that he sustained an accident/occupational disease arising out of and in the course of his employment, causing or contributing to cause his condition of ill-being.

2. Having failed to meet his burden of proof, Petitioner's claim is denied. This renders moot the other issues in dispute.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Marcus May,

Petitioner,

vs.

NO: 10 WC 21798

15IWCC0651

US Steel Granite City Works,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, notice, the nature and extent of Petitioner's 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 November 17, 2014, is hereby affirmed and adopted.

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

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

15IWCC0651

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

DATED: AUG 2 1 2015
TJT:yl
o 6/22/15
51

Thomas J. Tyrrell

Kevin W. Lamborn

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MAY, MARCUS
Employee/Petitioner

Case# **10WC021798**

U S STEEL
Employer/Respondent

15IWCC0651

On 11/17/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4613 GABRIEL McCARTNEY & WAGNER PC
MICHAEL CHEHVAL
720 OLIVE ST SUITE 2990
ST LOUIS, MO 63101

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0651

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Marcus May
Employee/Petitioner

v.

U.S. Steel
Employer/Respondent

Case # 10 WC 21798

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 **Belleville**, on **9/30/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **5/12/10**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**41,600.00**; the average weekly wage was $**800.00**.

On the date of accident, Petitioner was **55** years of age, ***married*** with **0** dependent children.

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

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

Respondent shall be given a credit of $**0** 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 $**31,720.00** under Section 8(j) of the Act.

ORDER

Petitioner did not prove accident, notice and causation. Therefore, the claim for PPD benefits is denied.

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

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

Signature of Arbitrator

11/7/14
Date

NOV 17 2014

Before the Illinois Workers' Compensation Commission

Marcus May,	)	
	)	
Petitioner,	)	
	)	
v.	)	No.: 10 WC 21798
	)	
U.S. Steel,	)	
	)	
Respondent.	)	

Findings of Fact:

Petitioner alleges wearing steel toed work boots resulted in amputation to the left second toe and disability of the left foot.

Petitioner worked 37 years for Respondent as a Heater. Respondent mandated Petitioner wear steel toed boots secondary to the temperatures. He walked around the mill and climbed stairs at least once a day.

Petitioner suffered from insulin dependent diabetes since 1997 and diabetic neuropathy since 2006. (Rx. 8 at 4; Rx. 6 at 17). He continues to suffer from those conditions along with hypertension, hyperlipidemia, diabetic retinopathy and erectile dysfunction. Dr. Ralph Oiknine, a board certified endocrinologist, testified these conditions are commonly associated with uncontrolled diabetes. (Rx. 4 at 9-10).

Petitioner testified that he treated with a podiatrist, Dr. Mitchell Needleman, starting in 2009 through early 2010, for a callus on his left second toe. On May 12, 2010, he came under the care of a vascular surgeon, Dr. Kosit Prieb. Dr. Prieb diagnosed osteomyelitis of the left second toe. On May 18, 2010, Dr. Prieb amputated the left second toe.

Petitioner testified that he first reported the condition as work related May 13, 2010 and completed an accident report June 21, 2010. (Rx. 2).

Post-operatively, Petitioner continued to treat with Dr. Prieb, a physiatrist Dr. Anwar Khan and a podiatrist Dr. James Taylor. On July 19, 2010, Dr. Khan performed EMG/NCS that revealed advanced sensory motor polyneuropathy in both feet. (Rx. 13 at 3-4). Dr. Prieb treated ulcers at the left great toe stump and left 5th toe in throughout 2011. (Px. E). Dr. Taylor treated the same ulcers throughout 2011 and 2012. (Rx. 14).

On February 5, 2013, Dr. Taylor performed surgery at Petitioner's third and fourth left toes. (Px. 14 at 37). The post-op diagnosis was chronic ulceration plantar metatarsal head #3 and displaced hammertoe deformity #3, #4. On June 17, 2014, Dr. Prieb removed the distal 3 cm of the left first metatarsal bone. (Px. E).

Petitioner testified he continues to experience bilateral foot numbness and tingling along with left foot pain. He has loss of balance and uses a cane to ambulate.

Petitioner has not returned to work for Respondent since May 2010. He voluntarily retired May 31, 2011. He receives a pension and social security disability.

PRE-2010 AMPUTATION

Petitioner testified that he injured his left great toe at work in 2008. He did not report it as work related. The Barnes and St. Elizabeth Hospital records reflect Petitioner denied any injury. (Rx. 7 at 1 and Rx. 8 at 4, 11). On February 8, 2008, Dr. Hans Moosa, a partner of Dr. Prieb, amputated the left great toe. (Rx. 8 at 27). Dr. Moosa's diagnosis was osteomyelitis from diabetic ulceration. He opined the condition did not arise out of the course of employment. (Rx. 11 at 4-6).

Petitioner returned to work full duty.

On July 29, 2009, Petitioner saw Dr. Needleman. He presented with ulceration at the left second metatarsal joint. Petitioner reported being on his feet all day at work and wearing special shoes that gave him problems. Dr. Needleman diagnosed a diabetic ulceration and performed treatment. Dr. Needleman recommended Petitioner stay off work and his feet to allow the ulcer to heal, get his diabetes under control and wear loose fitting shoes. (Rx. 1 at 10).

Similar exchanges occurred between Dr. Needleman and Petitioner 16 times between August 7, 2009 and May 3, 2010. (Rx. 1 at 10-26). Petitioner advised Dr. Needleman that his diabetes/blood sugars were not well controlled. (Rx. 1 at 15-25). Dr. Needleman consistently warned Petitioner about the risks and complications of the ulcer if Petitioner did not follow the recommendations. (Rx. 1 at 10-26).

Petitioner admitted he had 200 hours of vacation time and the chance to apply for A&S benefits in 2009.

Petitioner treated with Dr. Duk Kim, his primary care physician, for diabetes between January 24, 2000 and March 1, 2011. (Rx. 6). The records state Petitioner's diabetes was not well controlled and that on several occasions he failed to take his medication. (Rx. 6). The lab reports between March 10, 2000 and August 3, 2010, indicate elevated hemoglobin A1C levels. (Rx. 5).

DEPOSITION TESTIMONY

Petitioner deposed Dr. Prieb July 21, 2011. He opined Petitioner's left second toe condition arose out of work because he put pressure on the second toe and the problem with wearing the proper shoe. (Px. D at 18). He testified Petitioner might need additional care for his

toe or foot. (Px. D at 23). Dr. Prieb admitted that he did not discuss a return to work with Petitioner since May 13, 2010. (Px. D at 37). Dr. Prieb admitted that he could not determine whether standing at or outside work caused the left second toe ulcer that resulted in amputation. (Px. D at 40).

Respondent deposed a board certified orthopedic surgeon specializing in foot treatment Dr. Gary Schmidt September 23, 2011. Dr. Schmidt, following a record review, performed an independent medical examination May 2, 2011. Dr. Schmidt opined that Petitioner's diabetic neuropathy caused the left second toe amputation. (Rx. 3 at 12-13). Dr. Schmidt explained that Petitioner could return to work in extra depth steel toed work boots. (Rx. 3 at 14, 19, 21-22). Dr. Schmidt testified Petitioner was not totally disabled because Petitioner had already returned to work without his left great toe and that loss of the left second toe would have no impact on his ability to return to work. (Rx. 3 @ 14-15). Dr. Schmidt opined that the fact that Petitioner continued to develop ulcerations at the left foot despite the fact he was not working further supports the opinion that there is no relationship between the left second toe amputation and wearing the work boots. (Rx. 3 at 27).

Respondent deposed a board certified endocrinologist, Dr. Ralph Oiknine, September 9, 2011. Dr. Oiknine performed a medical record review, including the records from Dr. Duk Kim, the lab results, the records from Dr. Needleman and the records from Dr. Prieb. Dr. Oiknine opined the hyperlipidemia, poorly controlled diabetes, hypertension and diabetic neuropathy caused the left second toe ulcer. (Rx. 4 at 10-11).

Petitioner deposed a vocational specialist Delores Gonzalez October 25, 2013. She performed an assessment July 23, 2012. She opined it is unlikely Petitioner could return to work and if he found a job it would probably earn between $8.50 and $10.00 per hour. (Px. H at 9-10). She conditioned her opinion on a sedentary work restriction and conceded she did not have an opinion whether the restriction was appropriate or the cause of the restriction. (Px. H at 11-12).

Conclusions of Law:

Disputed Issues C & F – Accident and Causation

Petitioner did not prove he sustained an accidental injury arising out of and in the course of his employment working for Respondent.

In support of the conclusion, the Arbitrator finds Petitioner did not prove the work boots contributed the need for the second toe amputation or injury to the left foot. The opinions of Dr. Schmidt and Dr. Oiknine are more persuasive than the opinion of Dr. Kim. In contradiction to Petitioner's testimony, the medical records clearly document and support that Petitioner suffered from uncontrolled diabetes since 2000 and diabetic neuropathy since 2006. Dr. Schmidt and Dr. Oiknine explained that this caused the ulceration and ultimate infection and amputation of Petitioner's second left toe.

Furthermore, Dr. Prieb could not distinguish whether putting pressure on the left foot at work or away from work contributed to the ulcer that ultimately led to amputation.

Finally, despite not working since May 12, 2010, Petitioner continues to develop left foot ulcers resulting in the need for surgeries. This is consistent with the opinions of Dr. Schmidt and Dr. Oiknine that the uncontrolled diabetes caused ulcers and amputations.

Disputed Issue D & E – Accident Date and Notice

Even if Petitioner proved accident and causation, he did not give timely notice of a work accident.

In support of the conclusion, the Arbitrator finds the accident date no later than October 2009. Petitioner did not report a work accident until May 13, 2010, which is outside the 45 days notice requirement under Section 6(c) of the Act.

Petitioner alleges an accident date of May 12, 2010. The accident date in a repetitive trauma claim is the manifestation date, which is the date it becomes plainly apparent to a reasonable person a relationship could exist between the condition of ill-being and work. Various factors set the manifestation date including the date an employee requires treatment, the date employee can no longer perform the work activities, the severity of the injury and how the injury impacts the job performance. Durand v. Industrial Com'n, 224 Ill.2d 53, 72 (2006).

Petitioner admitted throughout 2009 that he felt the left second toe condition was related to wearing the work boot. He received treatment for the left second toe throughout 2009. Dr. Needleman advised Petitioner that he needed to come off work and stay off his feet in 2009.

These factors all support an accident date no later than October 2009. Petitioner admits that he did not report a work accident until May 13, 2010. Therefore, the claim is denied under Section 6(c) of the Act.

Disputed Issue L – PPD Benefits

Because Petitioner did not prove accident, notice and causation, the claim for PPD benefits is denied.

Petitioner did not prove permanent total disability or wage differential.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Ronald Kuzma,

Petitioner,

vs.

NO: 12 WC 003521

15IWCC0652

U.S. Steel,

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, temporary disability, permanent disability and section 8(j) credit for payment of non-occupational benefits and medical bills paid through the group insurance provider, and being advised of the facts and law, corrects, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

In the request for hearing form, the parties stipulated that Respondent is entitled a section 8(j) credit under the Act for all amounts paid through the group medical plan. The parties further stipulated that Respondent paid $14,299.24 in non-occupational indemnity disability benefits for which credit may be allowed under section 8(j) of the Act. These stipulations were omitted from the Decision of the Arbitrator, and the Commission hereby corrects the omission.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 15, 2014 is hereby corrected as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is entitled to the credit stipulated to by the parties under section 8(j) of the Act; provided that Respondent shall hold Petitioner harmless from any claims and demands by any of the providers of the benefits for which Respondent is receiving credit under this order.

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 $71,100.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 1 2015
o:6/25/15
SJM/msb
44

Stephen Mathis

Mario Basurto

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KUZMA, RONALD
Employee/Petitioner

Case# **12WC003521**

U S STEEL
Employer/Respondent

15IWCC0652

On 5/15/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1580 BECKER SCHROADER & CHAPMAN PC
TODD J SCHROADER
3673 HWY 111 PO BOX 488
GRANITE CITY, IL 62040

0299 KEEFE & DePAULI PC
ANDREW J KEEFE
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

15IWCC0652

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

RONALD KUZMA
Employee/Petitioner

v.

U. S. STEEL
Employer/Respondent

Case # **12** WC **003521**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edward Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **March 26, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **6/20/11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**70,036.20**; the average weekly wage was $**1,346.85**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** children under 18.

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

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

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

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

ORDER

The Arbitrator finds Petitioner's accident of June 20, 2011 arose out of and was in the course of his employment with Respondent.

The Arbitrator finds Petitioner's current condition of ill-being is causally related to his injury of June 20, 2011.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $35,873.06, as provided in Sections 8(a) and 8.2 of the Act.

Anderson Hospital	$18,423.06
Millenium Anesthesia	$ 2,205.00
Maryville Radiology	$ 35.00
Illinois Southwest Orthopedics	$15,210.00
Total	**$35,873.06**

Respondent shall pay Petitioner temporary partial disability benefits of $897.9 for 26 5/7 weeks commencing April 16, 2012 through October 20, 2012, as provided in Section 8(b) of the Act. The Arbitrator basis this finding based upon the medical records, the parties stipulations and the testimony of the Petitioner.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 /week for 37.95 weeks because the injuries sustained caused the 15% loss of use of the left arm as provided in Section 8(e)10 of the Act.

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

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

Signature of Arbitrator

5/12/14
Date

MAY 15 2014

On June 20, 2011, Petitioner worked in the maintenance services and utilities when he was attempting to retrieve materials to build a storage crate from a box in the yard and was surprised by a cat that jumped out of a crate. Petitioner spun around and hit his left arm on the crate and began having pain. He notified his supervisor and was sent to Veeder Health Center. The yard in which the boxes were located was fenced and was the property of Respondent. In addition, Petitioner testified the stray and feral cats had been an issue within the area for quite some time.

Petitioner was sent to Veeder Health Clinic, the company clinic, on June 20, 2011. (RX 5 at 1). Petitioner continued to treat with Veeder Health Clinic. On June 23, 2011, Petitioner was having increased pain, raising his arm at or above shoulder level. (RX 5 at 9). On July 26, 2011, Petitioner returned to Veeder Health Clinic and had increased pain with activity without any reinjury. (RX 5 at 14). Petitioner was discharged from the Clinic on August 24, 2011 stating that he had been working full duty since the date of incident with no difficulty. (RX 5 at 18). Petitioner returned on January 27, 2012 indicating that he still had pain with overhead flexion and/or abduction and indicates it has not felt or looked the same since the injury. (RX 5 at 21). At that time Veeder Health Clinic continued him on full duty work, no restrictions. (Id.)

Petitioner sought treatment with his family doctor, Dr. Michael Mulligan. He initially saw Dr. Mulligan on September 26, 2011. Dr. Mulligan indicated that it is not documented, but he was aware of the issue and was lead to believe was a work comp issues was why he did not address it in his notes. (PX 12 at 5). In September of 2011, Dr. Mulligan had told Petitioner he thought it was a rupture based on the physical appearance so that he put that in his assessment that he felt that he had a rupture of the biceps tendon. (PX 12 at 6). Dr. Mulligan further testified he did not have any other documentation of it because we were not the workers' comp providers and that is basically the recall I have of it. (Id.) Dr. Mulligan stated when Petitioner was seen again on January 16 he could have talked to Petitioner about the issue but it was not in his notes. (PX 12 at 6). A telephone log with a date of January 19 indicated that Petitioner had seen Dr. Mulligan on the 16th. He was aware of the left arm injury and states he needed a referral to Dr. Scherer for the torn biceps. (PX 12 at7). Dr. Mulligan indicated that Dr. Scherer is someone he normally refers patients to and he may have recommended Dr. Scherer to the patient prior to January 19, 2012. (PX 12 at7). Dr. Mulligan confirmed Dr. Scherer was in his normal referral pattern. (Id.). Under cross-examination, Dr. Mulligan made it perfectly clear that he did not document any of the workers' compensation discussions. (PX 12 at 9). Dr. Mulligan stated if he was aware that there was a workers' comp and I had told the patient that I don't do worker's comp and they asked me a question about it, I would not record it. (PX 12 at 16). Dr. Mulligan agreed that on September 26, 2011 and January 16, 2012 he would not have listed any of the left upper extremity problems if it was by the way conversation. It was certainly possible that he would not list any of the left upper extremity problems if that was a by the way conversation.

Petitioner was seen by Dr. Paul Scherer, an orthopedic surgeon. Dr. Scherer took a history of Petitioner being surprised by a cat which startled Petitioner causing him to jump backwards, crashing into a crate behind him. (PX 10 at 5). On examination, Petitioner had a subtle atrophy of the left deltoid, or a slight smaller size left deltoid when compared to the right. (PX 10 at 6). Dr. Scherer noted in his impressions the examination was suspicious for a rotator cuff tear and the tricky aspect was the issue of his biceps. (PX 10 at 7, 8). Dr. Scherer continued saying he probably either had a high grade tendinopathy of the biceps or subluxation, high grade tendinopathy meaning some partial tearing, but not completely torn, resulting in inhibition. Because he didn't have any signs of a neurologic cause for his biceps to be weak, it would additionally correspond to the findings of the biceps being smaller, so Dr. Scherer ordered an MRI scan, of course, of his left shoulder. (PX 10 at 8).

Dr. Scherer noted the MRI scan revealed prominent fluid along the long head of the biceps sheath and the long head of the biceps tendon looked thin, and there was a full thickness tear of the supraspinatus tendon and partial thickness tearing of the articular side of the upper aspect of the subscapularis, and those are the significant finding. Again with an enlargement of the AC joint that we, of course, saw on the MRI as well, I examined him again, and again found no tenderness to the AC joint on that date. He had a mild downsloping of the acromion as well. (PX 10 at 8). Dr. Scherer recommended surgical repair of the rotator cuff and probable biceps tendonesis. (Id.).

Petitioner was placed on restrictions on February 15, 2012 with a max five pounds lifting, pushing/pulling of the left arm. On April 16, 2012, Dr. Scherer performed surgery with the post-operative diagnosis being full thickness rotator cuff tear, left supraspinatus and upper infraspinatus tendons and biceps tendinopathy. (PX 7 at 1). The procedure was a diagnostic arthroscopy with limited arthroscopic debridement and open biceps tenodesis, acromioplasty and rotator cuff repair, left shoulder. (Id.) Dr. Scherer indicated that Petitioner's surgical findings were consistent with traumatic blow or muscular contraction or abrupt angular movement of the shoulder which would be consistent with his jerking back and falling onto some crates. (PX 10 at 22). Dr. Scherer reviewed Veeder records which stated Petitioner pointed to the middle of his left arm, medial side, so basically right over his biceps. Basically he complained of mid-biceps pain and weakness of flexion of his left elbow so any contraction of biceps caused this pain. (PX 10 at 24). Dr. Scherer stated in Petitioner's case, the Veeder notes wouldn't rule anything in or out and that Petitioner's case was somewhat confusing and it would not be surprising that the occupational medicine doctor would not be able to imagine the exact pathology that he had. (PX 10 at 25).

Dr. Scherer went on to say that earlier in his career he wouldn't have imaged exactly what he had except for having gone through cases when I am seeing guys back and back for months complaining of mid-biceps pain and I later find out through exhausted investigation that the whole time that he had a hole in his rotator cuff in the top and radiated pain into his biceps. It is one of these tricky things that is kind of like hip arthritis presenting as in interior knee pain and that is the only complaint. It's analogous to that. (PX 10 at 25). Dr. Scherer felt that the accident report of June 20, 2011 was consistent with the initial medical that he reviewed with Veeder and the operative report that we have gone over extensively that it was consistent, his complaints when he saw Dr. Scherer in the office were identical to what his initial complaints were on June 20, 2011, weakness and elbow flexion. (PX 10 at 25, 26). The Veeder records did not reveal any report of performing the Speed's maneuver, which is a specialized test that only an orthopedic surgeon would probably know. (PX 10 at 27). Dr. Scherer found this maneuver was positive on his initial evaluation. (Id.)

Dr. Scherer clarified in this case it was unusual that Petitioner had biceps area pain and his biceps weakness due to inhibition due to pain that he feels in the biceps is, in fact, due to his supraspinatus tear and superficial tearing and thinning of the long end of the biceps tendon. (PX 10 at 43). Dr. Scherer went on to state that this as a case of-- it is an unusual case of referred pain from the shoulder to the biceps. Continuing, Dr. Scherer indicated that if you go back to my original note of February 8, 2012, I did not describe any pain the shoulder either. He did not complain of any pain in the shoulder. (PX 10 at 43, 44). The only way I could find any symptom in the shoulder was digging my finger into the area where he had the tear, and he had mild tenderness there at the supraspinatus tendon. He also would have biceps pain when I would move his shoulder overhead but a lay person is going to think, well that is because my biceps hurt, but the reality is moving the arm, reaching overhead causes pain in the biceps because it is irritating the supraspinatus tendon and the long head of the biceps in the bicipital groove and referring pain or radiation pain-- referring is probably a better term to the mid-biceps area and that is why that is not diagnosed off the bat. (PX 10 at 44). Now, if he had come in and said—if he had been one of the usual people and said my shoulder hurts and the side of my shoulder and my mid deltoid right here, then an experienced guy like Dr. Parker is going to get an MRI of his shoulder and diagnose the problem immediately, but this case is weird because he only complained of pain in the biceps. (PX 10 at 44). In fact, when he came to be referred by Dr. Mulligan, Dr. Mulligan's clinical impression was that he

had a distal biceps tendon tear. (Id.) That was his presumption because he had atrophy pain and biceps. Dr. Scherer noted that the history of his observation started with that injury in June that we described at the last deposition would suggest that something happened at that time he tore the anterior aspect of the supraspinatus tendon. (PX 11 at 88). Dr. Scherer indicated that it was partially thinned and weakened and with that injury, that was the tipping point making his shoulder going from a shoulder that a laborer has who's in his 50s, has some degenerative changes in the tendon in the biceps groove, to being a shoulder that is then persistently painful. (Id.)

Petitioner testified that he continued to have pain in his arm continuously since the accident. Dr. Scherer opined that, within a reasonable degree of medical certainty, his rotator cuff tear was either caused by or aggravated by that June injury and the long head of the biceps, synovitis and thinning of tendon was not caused by but likely aggravated by that injury based on the fact that his symptoms started at that time. (PX 11 at 93). Dr. Lehman testified that it was possible to aggravate those long-term findings with the work injury if you got a true injury to your shoulder, yes it is possible. (RX 7 at 33).

Petitioner testified he was returned to full duty after completion of his medical treatment with Dr. Scherer. Petitioner further stated that he continues to have strength issues and issues working overhead with his left shoulder.

The Arbitrator finds the following:

1. The Arbitrator finds Petitioner's accident of June 20, 2011 arose out of and was in the course of his employment with Respondent. The location of the accident was completely under Respondents control. Furthermore, the crate in which Petitioner was reaching into when he was injured was located outside in a fenced in area in which cats had been an issue. The risk for Petitioner reaching into a crate and being surprised by an animal is higher than the general public.

2. The Arbitrator finds Petitioner's current condition of ill-being is causally related to his injury of June 20, 2011. The Arbitrator basis this finding on the testimony of Dr. Scherer, Dr. Mulligan and Petitioner.

3. Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule of $35,873.06, as provided in Sections 8(a) and 8.2 of the Act.

Anderson Hospital	$18,423.06
Millenium Anesthesia	$ 2,205.00
Maryville Radiology	$ 35.00
Illinois Southwest Orthopedics	$15,210.00
Total	**$35,873.06**

4. Respondent shall pay Petitioner temporary partial disability benefits of $897.9 for 26 5/7 weeks commencing April 16, 2012 through October 20, 2012, as provided in Section 8(b) of the Act. The Arbitrator basis this finding based upon the medical records, the parties stipulations and the testimony of the Petitioner.

5. Respondent shall pay Petitioner permanent partial disability benefits of $669.64 /week for 37.9 weeks because the injuries sustained caused the 15% loss of use of the left arm, as provided in Section 8(e)10 of the Act.

Dated: 5/12/14

Arbitrator Edward Lee

STATE OF ILLINOIS)
) SS.
COUNTY OF SANGAMON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Darrell Stewart,
Petitioner,
vs.
Conway Central Express,
Respondent,

NO: 11 WC 34902

15IWCC0653

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 19, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 21 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:6/25/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

STEWART, DARRELL
Employee/Petitioner

Case# **11WC034902**

CONWAY CENTRAL EXPRESS
Employer/Respondent

15IWCC0653

On 12/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1157 DELANO LAW OFFICES LLC
PATRICK JAMES SMITH
1 S E OLD STATE CAPITAL PLZ
SPRINGFIELD, IL 62701

0000 RUSIN & MACIOROWSKI LTD
MARK COSIMINI
2506 GALEN DR SUITE 106
CHAMPAIGN, IL 61821

15IWCC0653

STATE OF ILLINOIS)
)SS.
COUNTY OF SANGAMON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

DARRELL STEWART
Employee/Petitioner

Case # 11 WC 34902

v.

Consolidated cases: N/A

CONWAY CENTRAL EXPRESS
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 Arbitrator Molly Dearing**, Arbitrator of the Commission, in the city of **Springfield**, on **September 9, 2014.** After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of 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

15IWCC0653

On **February 3, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

Petitioner's current condition of ill-being of syncopal episodes ***is not*** causally related to the accident.
Petitioner's current condition of ill-being of post-concussive syndrome ***is*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$60,746.40**; the average weekly wage was **$1,168.20**.

On the date of accident, Petitioner was **44** years of age, married, with **1** child under 18.

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 **$78,658.80** for TTD and/or maintenance benefits, **$0.00** for TPD, and **$0.00** for other benefits, for a total credit of **$78,658.80**.

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

ORDER

Respondent shall pay all reasonable and necessary medical services and out-of-pocket expenses relative to Petitioner's concussion and post-concussive syndrome incurred from February 3, 2010 through December 13, 2011, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. All medical bills relative to Petitioner's syncopal episodes are denied as unrelated to Petitioner's work accident.

Respondent shall pay Petitioner temporary total disability benefits of $778.80/week for 96 6/7 weeks, commencing February 4, 2010 through December 13, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 50 weeks, because the injuries sustained caused the 10% loss of the person as a whole, as provided in §8(d)2 of the Act.

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

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

Arbitrator Molly Dearing

December 16, 2014
Date

DEC 19 2014

15IWCC0653

ILLINOIS WORKERS' COMPENSATION DECISION
CORRECTED ARBITRATION DECISION

DARRELL STEWART
Employee/Petitioner

v. Case # 11 WC 34902

CONWAY CENTRAL EXPRESS
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

At the time of his accident, Petitioner was forty four years of age (Arb. X 1), and employed by Respondent as a truck driver. He had been so employed since 1994. Petitioner obtained his commercial driver's license when he was seventeen years of age, and he testified that he has worked consistently since he was young. While employed by Respondent, he was certified to drive hazardous material, doubles, triples and tankers, and he had a passenger endorsement on his license. Petitioner's workday began at 5:00 a.m. He worked on the dock, spotted trailers in and out, and ran a route in Springfield delivering and retrieving freight to Respondent's terminal. His workday usually concluded between three and four in the afternoon, and he generally worked overtime.

On February 3, 2010, Petitioner was struck in the head by a load bar on a forklift truck. He lost consciousness and was taken by ambulance to Memorial Medical Center.

At Memorial Medical Center, Petitioner presented with a laceration on his forehead and complaints of continued confusion. Petitioner underwent a CT of the head without contrast, which revealed left supraorbital soft tissue swelling, but no underlying fracture or intracranial bleeding. A CT of the cervical spine was negative. Petitioner's forehead laceration was closed and he was discharged with prescription medication. PX 11.

On February 12, 2010, Petitioner presented to Dr. Christopher Wohltmann at SIU HealthCare with complaints of recurrent headaches following a trauma to his head at work with positive loss of consciousness. Petitioner also reported nausea, and flashes of light, floaters, and blurry vision in his left eye. Dr. Wohltmann stated that Petitioner's symptoms were consistent with post-concussive injury. Petitioner's forehead staples were removed, and Dr. Wohltmann recommended Petitioner present to an ophthalmologist. Dr. Wohltmann excused Petitioner from work until he was reassessed on February 19, 2010, and he restriction Petitioner from driving, lifting greater than ten pounds, and straining. PX 17.

On February 19, 2010, Petitioner returned to Dr. Wohltmann, at which time he reported a decrease in nauseousness, headaches, and left eye difficulties. Petitioner stated that he had ringing in his ears upon standing quickly or walking around with looking from the left to right, as well as equilibrium issues. Dr. Wohltmann's impression was post-concussive injury, and he recommended Petitioner follow up with an ears, nose, and throat specialist for possible positional vertigo versus closed head injury issues. Petitioner's restrictions of no driving, no heavy lifting, and no straining

were continued, and he was excused from work from February 19, 2010 through Marcy 1, 2010. PX 17.

On February 25, 2010, Petitioner presented to the emergency department at Memorial Medical Center with complaints of intermittent daily headaches from the level of his ears to the top of his head controlled with Tylenol, as well as vertigo, dizziness, abnormal balance, sensations of blood pumping in his head, nausea, blurry vision, and photophobia in his left eye. A brain MRI without contrast was taken and revealed no abnormalities, but showed mild scattered chronic appearing small vessel changes. Petitioner was diagnosed with cephalgia and vertigo. He was discharged with prescription medication, and ordered to follow up with Dr. James Crabtree, his primary care physician. PX 11.

On March 4, 2010, Petitioner presented to Dr. Richard Bass at SIU HealthCare for an evaluation of vertigo. Petitioner reported persistent problems with balance, following objects with his eyes, falling to the right while ambulating, difficulties with his memory, and unsteadiness with walking and unbalance to the point of falling since sustaining a traumatic head injury at work on February 3, 2010. Dr. Bass's impression was a gait disturbance most likely of central origin, and bilateral high tone sensorineural hearing loss. Dr. Bass recommended balance testing to further evaluate Petitioner's gait disturbance, and he referred Petitioner to Dr. Therese Meyer-Cox for further evaluation of his cognitive difficulties. PX 13.

On March 4, 2010, Petitioner presented to Dr. Jarrod Wall at SIU HealthCare in follow up to a traumatic head injury at work. Petitioner complained of persistent headaches, diminished concentration and memory, "as well as other post-concussive symptoms." Petitioner reported worsening headaches with lying flat, as well as nausea associated with his headaches. He denied changes in his vision. Dr. Wall's assessment was post-concussive injury, and he recommended Petitioner see a neuropsychiatrist, Therese Meyer-Cox, for an evaluation of his cognitive function. Dr. Wall excused Petitioner from work until March 26, 2010 and continued his restriction of no driving. PX 19.

On March 4, 2010, Petitioner presented to Dr. Cassandra Maillet, and complained of chills, daytime sleepiness, depression, dizziness, excessive fatigue, forgetfulness, headache, weight loss, nausea, nervousness, sweats, blurred vision, ringing in the ears, balance disturbance, itchy skin, memory loss and double or blurred vision. PX 25.

On March 19, 2010, Petitioner returned to Dr. Wall, and reported an improvement in his vertigo and dizziness, a cessation of his falling, and lessened headaches. Dr. Wall's impression was improving post-concussive syndrome. Dr. Wall excused Petitioner from work until April 16, 2010 and continued his driving restriction. PX 19.

On April 15, 2010, Petitioner underwent a neuropsychological evaluation with Dr. Therese Meyer-Cox due to Petitioner's ongoing cognitive complaints following a traumatic brain injury. Petitioner complained of difficulties with decreased speed of thought processing, difficulties with visual perceptual skills, being easily disorientated by fast moving objects, difficulties with short-term memory, increased irritability, decreased patience, mild difficulty with adjustment, and a hypersensitivity to stimuli in the environment, which he indicated began with his work-related accident on February 3, 2010. Following an examination, Dr. Meyer-Cox noted that Petitioner demonstrated a mix of intact and impaired cognitive abilities in a borderline to mildly impaired range

that were primarily affecting aspects of his memory and speed of thought processing. She further noted that Petitioner exhibited evidence of significant depressed mood as he endorsed 24 out of 30 symptoms associated with depression, which she indicated was consistent with moderately depressed mood and "is likely reflective of his currently [sic] difficulties with adjustment to his injury." PX 11.

Dr. Meyer-Cox opined that Petitioner would likely continue to progress and improve in his cognitive functioning, and that he will likely return in the next three to six months to his baseline level of cognitive functioning. Due to evidence of a moderately depressed mood secondary to difficulties with adjustment to his recent accident and residual symptoms from the accident, Dr. Meyer-Cox recommended Petitioner be seen for adjustment-related counseling to address such issues. PX 11.

On April 16, 2010, Petitioner presented to Dr. John Sutyak. He complained of persistent headaches since his work injury, as well as vertigo and postural instability. Petitioner reported that his balance and posture was improving with time, but he continued to complain of balance problems with leaning forward. He also reported a new onset of tinnitus since the week prior, and an episode of falling in the bathroom at Steak 'N Shake when the graphic tile pattern triggered his vertigo symptoms.. Dr. Sutyajk recommended a neurology consult for his visual disturbances causing him to fall to the ground and for Petitioner to continue to follow up with Dr. Bass. Dr. Sutyajk also excused Petitioner from work until he was evaluated by a neurologist. PX 21.

On April 21, 2010, Petitioner presented to Dr. David Gelber for an evaluation of post-concussive syndrome. He complained of persistent headaches in the bifrontal region, disequilibrium, and falls following an injury to his head at work on February 3, 2010. Dr. Gelber's assessment was post-concussive syndrome with symptoms consistent with headaches, dizziness, irritability, and problems with cognitive processing. He discussed the condition with Petitioner and his wife, and explained that it can take up to one year for post-concussive symptoms to maximally improve. Dr. Gelber ordered prescription medication of nortriptyline, excused Petitioner from work for two months, and restricted him from driving. PX 29. Petitioner returned to Dr. Gelber on June 21, 2010 and August 30, 2010. PX 29.

On September 8, 2010, Petitioner's wife called Dr. Gelber and reported that while mowing the grass, Petitioner felt nausea, dizziness, blurred vision and a headache before he passed out in the grass. Petitioner complained of a severe headache upon awakening with dissipating vision changes and nausea. Petitioner reported passing out two weeks prior and stated that he "overdid it today". The physician on call for Dr. Gelber ordered Topiramate and advised Petitioner to call Dr. Gelber in the morning. PX 29.

On September 17, 2010, Petitioner underwent an electroencephalogram, which was normal with no evidence of seizure activity, and on October 7, 2010, Petitioner underwent a 72-hour ambulatory electroencephalogram monitoring examination, which was normal awake, drowsy and sleep EEG patterns. PX 29.

Petitioner continued to present to Dr. Gelber for care and treatment of his post-concussive syndrome and syncopal spells. Dr. Gelber was unsure as to the etiology of Petitioner's spells, but continued to assess Petitioner with post-concussive syndrome. Dr. Gelber added Keppra to Petitioner's medication regimen. PX 29.

Dr. Joseph Dooley examined Petitioner on November 18, 2010 pursuant to Section 12 of the Act. Dr. Dooley noted that Petitioner appeared slow in thinking and responding to questions, his speech was hesitant but not aphasic, and his mood seemed depressed. Dr. Dooley also noted that his treatment appeared appropriate. After reviewing Petitioner's medical records, taking a history of his accident and symptomatology, and conducting a physical examination of Petitioner, Dr. Dooley assessed Petitioner with post-concussive syndrome. He opined that while his condition had improved since its onset, he noted that Petitioner still had considerable symptoms that are sufficiently disruptive to his general functioning such that he cannot work and should not drive with the episodes of loss of consciousness. Dr. Dooley opined that Petitioner should have an absolute driving restriction. Dr. Dooley recommended Petitioner begin a regiment of Keppra for his spells, and a work hardening program. RX 12.

On January 31, 2011, Petitioner underwent a neurophysiology laboratory electroencephalographic study over the course of six days, which was normal with no clinical spells and no evidence of any seizure activity. PX 29. Thereafter, Petitioner treated with Dr. Gelber, wherein Dr. Gelber increased Petitioner's dosage of Keppra, added additional medications to his regimen, and noted Petitioner's continued improvement in his symptomatology. PX 29.

On April 11, 2011, Dr. Dooley issued an addendum report following his review of surveillance video of Petitioner. He noted that during the surveillance, Petitioner is seen getting in and out of his truck "perfectly normal", driving and parking normally, walking and talking with comfort, ease and normally, without pain and imbalance or incoordination. Dr. Dooley commented that Petitioner appeared to function normal neurologically. PX 13.

On July 14, 2011, Petitioner underwent an examination with Dr. Karen Levin pursuant to Section 12 of the Act. After taking a history from Petitioner, reviewing his medical records, and conducting a neurologic examination, Dr. Levin opined that Petitioner suffered from post-concussive syndrome in which he continued to exhibit symptomatology. She stated that she would have suspected that from that type of injury, Petitioner should have had symptom resolution quite some time ago. As a result, Dr. Levin recommended Petitioner undergo neuropsychological testing with Dr. Nancy Landre. She stated that further recommendations on work restrictions and maximum medical improvement will depend on the results of Dr. Landre's testing. RX 14.

On November 11, 2011, Petitioner underwent neuropsychological testing with Dr. Nancy Landre. Petitioner underwent a clinical interview with Dr. Landre, she reviewed his medical records, and she performed a standardized assessment of cognitive and emotional functioning. Dr. Landre stated that the results of Petitioner's evaluation do not support an impression of malingering, but indicated that his "mildly elevated score on the Symptom Validity scale of this instrument raises concern regarding the possibility of somatic malingering. Thus, while Mr. Stewart's cognitive performance is likely valid and appropriate for interpretation, his symptom report regarding his somatic complaints and emotional functioning may reflect some degree of exaggeration or over-reporting of symptoms." RX 15.

Upon examination of Petitioner's emotional functioning, Dr. Landre found that Petitioner exhibited strong psychological components of somatic complaints. "Specifically, persons with this profile are prone to develop physical symptoms in response to psychological stress. They also tend to be preoccupied with their perceived poor health, to have a low tolerate for frustration, and to not cope well with stress. In addition, Mr. Stewart's responses reflect an elevated level of hopelessness

and pessimism...The most common diagnosis for persons with this profile is Somatoform Disorder." RX 15.

Dr. Landre opined that Petitioner "has certain personality characteristics that predispose him to develop physical symptoms in response to psychological distress. Specifically, while Mr. Stewart's cognitive work-up was mostly within normal limits, his psychological work-up was abnormal, with findings most consistent with a Somatoform Disorder." Dr. Landre noted that the few cognitive abnormalities that Petitioner demonstrated upon examination "likely represent premorbid limitations, rather than injury-related declines in functioning", that "all other cognitive indices was within normal limits for someone of his age and educational background", and that his demonstrated unexpectedly weak bilateral performance on fine motor dexterity measure was inconsistent with his injury. Dr. Landre opined that from a cognitive standpoint, Petitioner was capable of resuming his previous work duties as a driver and sales representative. RX 15.

Following her review of Dr. Landre's report, Dr. Levin authored a narrative report dated December 13, 2011. Therein, Dr. Levin stated that Petitioner's Somatoform disorder "means that he tends to make his symptoms greater than they actually are and to make physical symptoms out of ones that do not exist." Based upon Dr. Landre's findings and her own findings of July 14, 2011, Dr. Levin opined that Petitioner has no continued neurologic disability resultant from any alleged injuries of February 3, 2010. She opined that Petitioner suffered post-concussive syndrome as a result of that accident that resolved, and that he was not in need of further neurological treatment. Dr. Levin stated that Petitioner can return to work without restrictions from a neurologic standpoint, desist from further medication use, and resume driving. RX 16.

On December 9, 2011, Petitioner requested clarification from Dr. Gelber as to whether he had placed any restrictions upon Petitioner's driving. Dr. Gelber indicated that Petitioner can drive without restriction. RX 11.

On April 16, 2012, Petitioner returned to Dr. Gelber for a follow up visit, at which time he suffered a syncopal episode while in the waiting room. Dr. Gelber noted no tongue biting, incontinence or abnormal motor activity. Petitioner was out for approximately one minute and was awakened with smelling salts. Dr. Gelber noted that Petitioner was able to converse appropriately thereafter. PX 29.

On April 22, 2012, Dr. Gelber prepared a narrative report, wherein he opined that Petitioner suffers from post-concussive syndrome and episodes of syncope with no defined etiology. He agreed with Dr. Landre that Petitioner's complains had some somatoform component because the episode Dr. Gelber observed in his office did not appear to be of a neurologic cause. He believes that "the injury described is responsible for Mr. Stewart's ongoing complaints." He indicated that he may recommend a functional capacity evaluation should the question of Petitioner's ability to work continue to remain contentious. PX 29.

Dr. Levin testified by way of evidence deposition on August 30, 2012. Dr. Levin testified concomitantly with her report of July 14, 2011. She stated that Petitioner's MRI scan of his brain revealed "little old scars" generally indicative of a history of migraine headaches, strokes, and old trauma. Dr. Levin opined that Petitioner's MRI findings were not related to his July 3, 2010 work accident. She also stated that Petitioner scored 24 out of 30 on a mini-mental examination, though he was unable to write a sentence and could recall only two of three objects. Dr. Levin opined that

as a result of his work accident of February 3, 2010, Petitioner suffered a mild concussion with post-concussive syndrome that improved within six months of his injury. She opined that Petitioner would have returned to his baseline condition within one year of his injury. Dr. Levin testified that she found nothing suggestive of continuing neurological conditions. RX 17.

Dr. Levin testified that Petitioner's continued symptomatology were not caused by a neurological condition, as there were no findings on Petitioner's clinical examination to explain his symptoms and his multiple electroencephalograms did not reveal any seizure focus. She testified that there were aspects of Petitioner's examination that suggested he was embellishing his symptomatology because his examination was "internally inconsistent", as he was able to mentally compute a mathematical calculation, rapidly name fifteen animals, and construct a clock, but he was unable to name more than two American presidents or count the months of the years backwards. Dr. Levin. Following receipt of the neuropsychological testing of Dr. Landre, Dr. Levin opined that Petitioner required no neurological restrictions, and that he was able to drive without restrictions. RX 17.

Dr. Gelber testified by way of evidence deposition on May 21, 2013. Dr. Gelber is a neurologist with the Springfield Clinic in Springfield, Illinois, and he is board certified in neurology and electrodiagnostic medicine. Dr. Gelber explained that a concussion is essentially a severe blow to the head. He indicated that symptoms generally associated with a concussion include headaches, neck pain, dizziness, change in mood/irritability, depression and cognitive deficits, including difficulties with short-term memory, attention, concentration, and multitasking. Dr. Gelber explained that these symptoms may vary with each individual and may vary in severity. The severity of the concussion is based on the symptoms they have, the severity of the symptoms, and their duration. PX 29.

Dr. Gelber diagnosed Petitioner with post-traumatic syndrome. He stated that in September 2010, Petitioner complained of syncopal spells or blacking out. However, Dr. Gelber acknowledged that he does not know what is causing the episodes of syncope. He indicated that he believed the spells are psychiatric, but he did not believe that Petitioner was passing out purposefully and believed Petitioner to be truthful. Dr. Gelber stated that he believed the spells were a somatoform disorder, which is usually brought on by stress or anxiety. He explained that somatoform disorder is a physical manifestation of stress or anxiety, and is different from malingering. Dr. Gelber further explained that malingering is an intentional act, whereas somatoform disorder is unconscious in nature, e.g. stomachaches before tests. PX 29.

Dr. Gelber testified that Petitioner's spells are not related to any heart disease, neurologic disease, and are not directly related to any concussion resultant of a head injury. Dr. Gelber stated that, "I mean they're indirectly related in terms of whatever psychiatric stressors might be precipitating those; but no, they're not a direct effect of a head injury. The head injury or the concussion did not cause an injury to the brain that's making him pass out." Dr. Gelber opined that marital difficulties could lead to psychiatric problems, and could explain the stress causative of his syncopal spells. He stated that Petitioner' syncopal spells are not "caused by a brain injury, but I think it's stress reaction to something that's going on. I can't say for sure that it's a stress reaction due to his concussion. I was already asked, well, could marital difficulties or things at home, well, sure, it could be a reaction to any of those. So I don't know that I could say with medical certainty what it's related to." Dr. Gelber stated that if Petitioner did not have such spells prior to his head trauma, then one may assume the trauma may be related, but he acknowledged that because

Petitioner did not have such episodes until months after his trauma, it was less likely to be either directly or indirectly related to his work injury. PX 29.

Dr. Gelber testified that Petitioner's symptoms essentially remained unchanged from the beginning of his treatment until the present. Dr. Gelber testified that he has prescribed numerous medications in an attempt to alleviate Petitioner's headaches, but he acknowledged that Petitioner's headaches and depression are his only treatable symptoms. Dr. Gelber stated that Petitioner's headaches, dizziness, cognitive deficits and depression are consistent with post-traumatic syndrome, though the syncopal spells are not. Dr. Gelber conceded that Petitioner's reported symptoms of food tasting peppery and losing sensation of carbonation in soda days before a syncopal spell was "kind of funky". PX 29.

Dr. Gelber testified that Petitioner should not be driving. He explained that Illinois State law mandates that anyone who suffers a loss of consciousness should not drive for six months, and that he discussed this with Petitioner. Dr. Gelber stated that if Petitioner continued to drive, then "that's a problem." PX 29.

On August 2, 2013, Petitioner returned to Dr. Gelber in follow up for post-concussive syndrome. Petitioner reported doing better on the Keppra medication and improved headaches, though he continued to complain of occasional headaches and syncopal spells every five to 20 days. Dr. Gelber's assessment was post-concussive syndrome, and he recommended Petitioner continue with his current treatment and return in six months. PX 45.

On October 14, 2013, Petitioner presented to Dr. Rodica Brisan with complaints of "anger problems." Petitioner reported being a "happy go lucky" person prior to the accident, but stated that following the accident it did not take a lot to "set me up" and that his wife would not tolerate his anger. Dr. Brisan assessed Petitioner with post-concussive syndrome and mood disorder secondary to general medical condition. Petitioner returned to Dr. Brisan on January 7, 2014 with a report of decreased anger episodes. Dr. Brisan described his affect at that time as calm with an occasional smile. She stated that, "[t]he "only question that the patient had for me was if I received the papers from his lawyer and what was my expert opinion about his passing out. Secondary game [sic] might be involved." Petitioner was instructed to comply with his medication regimen and to follow up in three months. PX 38

On February 3, 2014 and August 5, 2014, Petitioner returned to Dr. Gelber and complained of continued occasional headaches and syncopal spells. Dr. Gelber noted his course to be stable and that "[h]e really has not had any change." Dr. Gelber ordered Petitioner to continue his current treatment and to return in six months. PX 45.

On April 29, 2014, Petitioner presented to Dr. Brisan with complaints of severe depression, continued reports of syncopal episodes, and intermittent passive suicidal thoughts. Dr. Brisan's assessment remained post-concussion syndrome and mood disorder due to a general medical condition. Dr. Brisan altered Petitioner's prescription medication, ordered a liver function panel, a TSH test, and prescribed Depakene. PX 38.

At Arbitration, Petitioner testified that he was involved in several civic organizations, including Waverly Lions Club, Waverly Sports Boosters, Waverly Fire Department, and the

Sangamon County Fair prior to his work accident of February 3, 2010. Since that time, his involvement has been limited to Sangamon County Fair and the Lions Club.

Petitioner testified that he continues to suffer from headaches, depression and syncopal episodes. He takes Keppra, Depacote, Cymbalta, and a generic form of Prozac for symptom management. Petitioner also uses Ibuprofen or Tylenol for relief of his headaches, which he stated vary in severity. He described feeling useless because he cannot function as he was prior to the accident, and he is treating with a psychiatrist for his depression. Petitioner acknowledged taking depression medication prior to his work accident prescribed by his primary care physician, Dr. Crabtree, but he did not believe that he was taking such medication at the time of the accident. Petitioner did not inform Dr. Gelber that he took medications relative to depression prior the accident. He acknowledged that his functionality, stability and speech have dramatically improved since the accident.

Petitioner denied experiencing syncopal episodes prior to the accident, but he testified that he has experienced numerous syncopal episodes since his work accident. Petitioner's recorded history of episodic blackouts from November 24, 2010 through February 7, 2013 were admitted as Petitioner's Exhibit 31, and his hand-written histories from November 24, 2010 through February 20, 2013 were admitted as Petitioner's Exhibit 36. Petitioner testified to blacking out while stripping shingles from a roof, digging a 20 to 25 foot trench to run a power line pole to a new building, and mowing the grass. He testified that he does not recall the episodes until he awakens. Petitioner continues to sleep in a recliner approximately one or two times per month. He acknowledged driving from his home in a rural area of Waverly, Illinois approximately a mile and a half into town to the local coffee shop daily, unless his headaches are intolerable, though he denied driving at night. Petitioner testified that he drives his son to school five days per week, and he is unconcerned about his son being in the car with him because he stated that his son is aware of his episodes. He testified that everyone residing on his road is aware of his condition, as is the Waverly Police Department and Post Office.

Petitioner is divorced, and has been since March 2011. He testified that the divorce was amicable and that he and his former spouse get alone well. Petitioner denied that his marital difficulties increased his depression. Petitioner currently resides with his brother and sister-in-law, Merril and Dana Stewart, in Waverly, and he has been living with them since October 2010.

Petitioner is not presently employed. He testified that Respondent has not offered him a position since his work accident, nor has Respondent offered vocational rehabilitation services. Petitioner testified that he has inquired about work within his town of Waverly, but stated that he cannot obtain employment as long as he has syncopal episodes. Petitioner's commercial driver's license was suspended by the State of Illinois because he failed the physical examination due to his syncopal episodes. PX 27. Petitioner applied for Social Security Disability, and indicated his syncopal spells and depression were the basis for the application. He currently works on his mother's farm, feeding and watering the cattle, and mending fences.

David Lambert testified at Arbitration on behalf of Petitioner. Mr. Lambert is a driver sales representative for Respondent. He has known Petitioner for fourteen years, and he worked with him prior to the work accident. Mr. Lambert described Petitioner as an excellent worker, cheerful and outspoken, and who never missed a day of work. Mr. Lambert stated that Petitioner could "talk

forever" prior to February 3, 2010. Mr. Lambert was present on February 3, 2010 when Petitioner was struck by a swing bar of a forklift and lost consciousness.

Mr. Lambert testified that subsequent to February 3, 2010, Petitioner's concentration is such that if their discussion is interrupted, he will restart the conversation from the beginning. Petitioner presently fails to remember to return phone calls and speaks less than he did prior to the accident, though Mr. Lambert acknowledged that Petitioner continues to be conversational at the local coffee shop.

Sharon Stewart, Petitioner's mother, testified at Arbitration on behalf of Petitioner. Mrs. Stewart described her son prior to February 3, 2010 as a hard worker who interacted well with his siblings and had a lot of friends. She testified that at that time, Petitioner did not have any difficulties walking or speaking. After February 3, 2010, she noticed that his walk was unsteady and his speech was slow. Presently, she notices that his balance and speech has greatly improved, and he does not hesitate as long to answer. Ms. Stewart owns a farm, and she acknowledged that Petitioner continues to work on her farm. She testified that he does not do as much work on the farm as he did before his work accident, and he now has to be told what to do.

Ms. Stewart testified that she kept a log of Petitioner's syncopal episodes for the benefit of his physicians. She documented all incidents, and noted if he struck his head and in which direction he fell. She indicated that Petitioner has struck his head approximately 80% of the time he has passed out, and he falls to the left 90% of the time. Mrs. Stewart testified that Petitioner has passed out into cattle manure, and in a trench.

Aaron Caruthers testified at Arbitration on behalf of Petitioner. Mr. Caruthers has resided in Waverly, Illinois his entire life, and he is a Registered Nurse at Springfield Clinic. Mr. Caruthers testified that he has known Petitioner for a significant length of time. Mr. Caruthers has observed Petitioner in social settings, and has previously worked with him performing HVAC work. Mr. Caruthers described Petitioner as a "workaholic" prior to February 3, 2010, and denied that Petitioner suffered from any difficulties with speech, stability, ambulating or interacting with others at that time.

Mr. Caruthers testified that he witnessed Petitioner pass out while at Petitioner's mother's home. Mr. Caruthers stated that prior to Petitioner's episode, Petitioner fixed a plate of food and Mr. Caruthers noted his movements were slow, as if "watching a toddler." Petitioner rubbed his neck before he passed out for three to five minutes. When Petitioner awakened, Mr. Caruthers testified that Petitioner was shaking, and instantaneously drank a twelve-ounce bottle of water before sitting down. Mr. Caruthers described Petitioner as foggy, and as suffering from impaired motor capabilities upon awakening.

Mr. Caruthers testified that subsequent to February 3, 2010, he does not believe Petitioner's speech to be as upbeat as it was before that time, his walking is not as sharp, he is more irritable, and his motor skills are slower than prior to the work accident. Mr. Caruthers indicated that Petitioner appears to have little motivation because he is unable to do many things, and that Petitioner does not have the same demeanor as he did prior to his work accident.

Melissa Stewart testified at Arbitration on behalf of Petitioner. Ms. Stewart resides in Waverly, and she has known Petitioner since 1982. Ms. Stewart and Petitioner were married and

have two children together. Their marriage was dissolved on April 11, 2011, and the proceedings were amicable. Ms. Stewart testified that Petitioner's work accident of February 3, 2010 was a contributing factor in the dissolution of their marriage because following the accident, Petitioner became moody, he was unable to interact with her or their children, and he was unable to function as he had previously. She stated that within a few days of his work accident, it was evident that Petitioner was not the same person she married.

Ms. Stewart described Petitioner as a hard worker prior to February 3, 2010, though following the work accident, she testified that Petitioner was unable to work, climb stairs, or stand to wash dishes because of his pain, and he instead spent most of his time lying in a reclining chair. Ms. Stewart testified that Petitioner is presently slower in speech and movement, it takes longer for Petitioner to form words, and his mood has declined.

Ernest Cleveland testified at Arbitration on behalf of Petitioner. Mr. Cleveland presently owns a restaurant in Waverly. He testified that he has known Petitioner most of his life, as prior to February 3, 2010, he lived two houses down from Petitioner, and Petitioner previously worked for him in the evenings driving grain trucks for Johnson Grain. Prior to February 3, 2010, Mr. Cleveland testified he saw Petitioner two to three times per week, but he was unable to socialize with Petitioner because he was always working. At that time, Mr. Cleveland did not notice anything unusual about Petitioner's speech or motor skills, and he described Petitioner as a hard worker.

Subsequent to February 3, 2010, Mr. Cleveland testified that he sees Petitioner at least every other day as Petitioner comes into Mr. Cleveland's restaurant. Mr. Cleveland testified that Petitioner has good days and bad ones. On days in which Petitioner does not feel well, he sits in a recliner, drinks coffee, and does not move. Mr. Cleveland testified that Petitioner lacks a good sense of humor following his work accident, and that his speech is presently slow and deliberate. Mr. Cleveland described Petitioner as "bored" because "[h]e can't do anything."

Mr. Cleveland drives Petitioner home from the restaurant if Petitioner cannot do so, and he testified that he has observed Petitioner pass out on many occasions. Following these episodes, Mr. Cleveland described Petitioner as stiff. He indicated that they no longer take Petitioner to the hospital after he awakens from an episode, but rather, they make him comfortable and give him a 24-ounce glass of water to drink. Mr. Cleveland testified that Petitioner's current episodes are different from those he has suffered previously in that Petitioner passes out for a second time before he completely revives from the first, whereas he used to only suffer a single episode at a time.

Candace Albrecht testified at Arbitration on behalf of Petitioner. Ms. Albrecht has resided in Waverly, Illinois for approximately fourteen years, and she presently works in Jacksonville. Ms. Albrecht was previously employed at the restaurant owned by Ernest Cleveland and his wife. Prior to February 3, 2010, Ms. Albrecht saw Petitioner daily, and did not notice any difficulties with his speech, gait, or interaction with other people at that time.

After February 3, 2010, Ms. Albrecht testified that Petitioner walks to the left, and he has difficulty processing words. She has observed him passing out, and she described Petitioner as "dead weight" during such episodes. Ms. Albrecht testified that when Petitioner awakens from an episode, that he shakes and he "looks right through you."

Merril Stewart, Petitioner's younger brother, testified at Arbitration on behalf of Petitioner. Mr. Stewart is presently employed as a truck driver and he has resided in Waverly, Illinois his entire life. Mr. Stewart previously worked construction with Petitioner, as well as performing remodeling work and driving trucks. Prior to February 3, 2010, Mr. Stewart has worked alongside Petitioner around their mother's farm building fences, bailing hay, and caring for livestock. Prior to Petitioner's work accident, Mr. Stewart described his brother as a "go-getter" and indicated that Petitioner worked continuously. At that time, Mr. Stewart he did not notice anything unusual about the Petitioner's ability to walk, to interact with people, or with his motor skills. He never observed Petitioner passing out prior to his work accident. After February 3, 2010, Mr. Stewart testified that Petitioner's movements, speech, and ability to process information are slower than they were before his work accident.

Mr. Stewart has observed Petitioner pass out on numerous occasions, including while working at a cattle lot, sitting on the hay rack, sitting on the round bale, building a dry dam, and while roofing. Mr. Stewart testified that Petitioner passes out approximately every 14 days, and within two days before passing out, Petitioner becomes very irritable and angry. Mr. Stewart indicated that Petitioner generally losses consciousness for two to three minutes, he has also been out as long as 35 minutes. Mr. Stewart testified that Petitioner has difficulty looking in an upwards direction, and becomes very dizzy when he does so and must sit down.

Surveillance video was admitted as Respondent's Exhibit 18. The videos reflect surveillance obtained on September 8, 2010, September 9, 2010, November 1, 2010, November 2, 2010, January 27, 2011, January 28, 2011, May 11, 2011, and May 17, 2011. The videos generally reflect Petitioner getting in and out of his automobile, driving, entering and exiting establishments in Waverly, smoking, ambulating, conversing with other individuals, talking on his cell phone, and petting his dog. RX 18.

CONCLUSIONS OF LAW

The Arbitrator finds David Lambert, Sharon Stewart, Aaron Caruthers, Melissa Stewart, Ernest Cleveland, Candace Albrecht, and Merril Stewart to be credible witnesses, as they appeared candid and forthcoming in their demeanor and testimony at Arbitration, even on cross examination.

The Arbitrator concludes that Petitioner's current condition of syncopal spells is not causally related to his work accident. In so concluding, the Arbitrator finds the absence of any syncopal episodes in the seven months following the February 3, 2010 accident probative of a lack of a causal relationship. The medical evidence indicates that Petitioner's syncopal episodes are inconsistent with post-concussive syndrome (PX 29), and are not a result of a neurological injury, but are instead secondary to somatoform disorder and triggered by psychiatric stressors. PX 29, RX 15, 16. Although Dr. Gelber originally opined that Petitioner's syncopal episodes were indirectly related to his work accident in that psychiatric stressors secondary from the accident could be causative of his episodes, he later testified that he could not opine that Petitioner's episodes were stress reactions "due to his concussion…I don't know that I could say with medical certainty what it's [his episodes] related to." Dr. Gelber further opined that while an absence of such episodes prior to sustaining head trauma on February 3, 2010 suggested a causal relationship to the work accident, he acknowledged that the absence of any episodes in the months following the accident lessened the likelihood that they were either directly or indirectly related to his work injury. PX 29. The Arbitrator is dissuaded from assigning the opinions of Dr. Gelber significant evidentiary weight due

to their equivocalness, and the Arbitrator is disinclined to find causation where Petitioner's treating physician is unable to causally connect his syncopal episodes to his work accident.

The Arbitrator instead finds the opinions of Dr. Levin and Dr. Landre persuasive. Drs. Levin and Landre not only reviewed Petitioner's treating records, but also physically examined Petitioner, and Dr. Landre performed additional neuropsychological testing. Based upon her examination, her review of Petitioner's records, and the examination and testing performed by Dr. Landre, Dr. Levin opined that Petitioner suffered from a concussion and post-concussive syndrome that was causally related to his work accident of February 3, 2010. She further opined that Petitioner was not in need of further neurologic treatment, and that he could return to work without restrictions from a neurologic standpoint, desist from further medication use, and resume driving. RX 14, 16, 17. Dr. Levin's opinion regarding Petitioner's ability to resume work without restrictions was echoed by Dr. Landre, who opined that Petitioner was capable of resuming his previous work duties as a driver and sales representative. RX 15. The Arbitrator finds the reverberation of Dr. Landre's opinions with that of Dr. Levin to be compelling, and accordingly places great weight on their opinions.

Although Petitioner proffered multiple witnesses who testified at Arbitration to witnessing Petitioner's syncopal spells, the Arbitrator questions the legitimacy of such episodes, given that Petitioner continues to drive everyday against medical advice and with his son in his vehicle. While Petitioner is unconcerned about driving with his son alongside him because he states his son is aware of his condition, the Arbitrator is not persuaded by his justification, given that his son's knowledge of the condition will not protect him, Petitioner, or other people in an automobile accident should they be involved in one secondary to Petitioner suffering a syncopal episode while driving.

The Arbitrator additionally questions the veracity of Petitioner's reports of his symptomatology in light of the concern of Dr. Brisan, Petitioner's treating psychiatrist, that secondary gain "might be involved" in this case. PX 38. Dr. Brisan's concern parallels that of Dr. Levin, who suggested that Petitioner may be malingering his symptoms (RX 14, 16, 17), and the notation of Dr. Landre that Petitioner's report of symptoms relative to his somatic complaints and emotional functioning may reflect some degree of exaggeration or over-reporting. RX 15. Further, the Arbitrator notes the testimony of Petitioner's brother, Merril Stewart, that Petitioner cannot look up without becoming dizzy and sitting down, though the surveillance video from September 9, 2011 depicts Petitioner looking up at a brick building while talking alongside another individual without any indications of affect resultant therefrom. In light of the foregoing, the Arbitrator finds Petitioner's alleged syncopal episodes and his reports of symptomatology suspect.

The Arbitrator finds that Petitioner's current condition of post-concussive syndrome is causally related to his work accident. The medical opinions of Dr. Gelber, Dr. Dooley, and Dr. Levin all concur that Petitioner sustained post-concussive syndrome as a result of his work injury on February 3, 2010. PX 29, RX 12, RX 14, RX 16, RX 17. Dr. Gelber testified that Petitioner's current complaints of headaches and depression are consistent with post-concussive syndrome (PX 29), and the medical evidence demonstrates that Petitioner developed an onset of headaches contemporaneously with the February 3, 2010 work accident, and a development of irritability, mood disorder, and depression in a reasonable time period thereafter. PX 11, 25, 29. Petitioner denied experiencing headaches prior to his work accident, and while Petitioner may been taking prescription anti-depressant medication on and before February 3, 2010 (PX 11), there is no

evidence to suggest that any depression-related symptomatology he suffered prior to the accident necessitated treatment with a neurologist or psychiatrist as it did subsequent to sustaining his work injury.

Based upon the aforementioned findings, the Arbitrator concludes that Petitioner has failed to prove by a preponderance of the credible evidence that his current condition of syncopal episodes is causally related to his work accident of February 3, 2010. The Arbitrator further concludes that Petitioner's current condition of post-concussive syndrome is casually related to his work accident of February 3, 2010.

In regard to disputed issue (J), the Arbitrator finds that medical services rendered following the accident through December 13, 2011 for Petitioner's concussion and post-concussive syndrome were reasonable and necessary in Petitioner's care and treatment. On December 13, 2011, Dr. Levin opined that Petitioner was not in need of further neurologic treatment (RX 16), which is supported by the medical evidence, as Petitioner's post-concussive syndrome appears to have stabilized as of that date. On December 5, 2011, Petitioner reported to Dr. Gelber an improvement in his headaches, and thereafter, Dr. Gelber noted Petitioner's condition to be stable, and Petitioner's complaints and Dr. Gelber's treatment regimen essentially remained unchanged. PX 29, 45. Therefore, the Arbitrator awards medical bills and Petitioner's out-of-pocket expenses relative to Petitioner's concussion and post-concussive syndrome from the date of accident through December 13, 2011. Respondent shall pay all reasonable and necessary medical services and out-of-pocket expenses for Petitioner's concussion and post-concussive syndrome incurred from February 3, 2010 through December 13, 2011, as provided in Sections 8(a) and 8.2 of the Act, and subject to the fee schedule. All medical bills and expenses relative to Petitioner's syncopal episodes are denied as unrelated to Petitioner's work accident, given the Arbitrator's conclusions with respect to issue (F).

In regard to disputed issue (K), and in light of the Arbitrator's foregoing conclusions, Respondent shall pay Petitioner temporary total disability benefits for 96 6/7 weeks, commencing February 4, 2010 through December 13, 2011, at which time Petitioner's post-concussive syndrome stabilized, Petitioner could return to work without restrictions, and he no longer needed further neurologic treatment. RX 16. Respondent shall be given a credit of $78,658.80 for temporary total disability benefits previously paid.

In regard to disputed issue (L), as a result of his work accident of February 3, 2010, Petitioner suffered a concussion and subsequent post-concussive syndrome. While Petitioner's post-concussive syndrome has significantly improved, Petitioner testified that he continues to suffer from headaches for which he takes ibuprofen or Tylenol, and depression managed with prescription medication and psychiatric treatment. Petitioner testified that his medications relative to his syncopal episodes and depression also alleviate his headaches.

The Arbitrator notes that at Arbitration, Petitioner was able to easily recall information, and he did not exhibit any speech, concentration, or functional difficulties. The testimony elicited at Arbitration and the surveillance video admitted suggests that Petitioner's present complaints do not interfere with his activities of daily living, as he is able to drive, converse and interact with others, and perform laborious work, such as stripping shingles off a roof, digging trenches, and performing farm work. Based upon the foregoing and the record in its entirety, the Arbitrator finds that Petitioner has suffered permanent partial disability to the extent of 10% of the person as a whole, pursuant to Section 8(d)2.

STATE OF ILLINOIS)
) SS.
COUNTY OF WILLIAMSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Terie Brewer,
Petitioner,

vs.

NO: 12 WC 28158

Chester Mental Health Center,
Respondent,

15IWCC0654

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 20, 2014 is hereby affirmed and adopted.

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

No bond or summons for State of Illinois cases.

DATED: AUG 21 2015

MB/mam
o:6/25/15
43

Mario Basurto

David L. Gore

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BREWER, TERIE
Employee/Petitioner

Case# **12WC028158**

15IWCC0654

CHESTER MENTAL HEALTH CENTER
Employer/Respondent

On 10/20/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4075 FISHER KERHOVER & COFFEY
JASON E COFFEY
PO BOX 191
CHESTER, IL 62233

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0558 ASSISTANT ATTORNEY GENERAL
KYLEE J JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

OCT 20 2014

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

15IWCC0654

STATE OF ILLINOIS)
)SS.
COUNTY OF **Williamson**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Terie Brewer
Employee/Petitioner

v.

Chester Mental Health Center
Employer/Respondent

Case # **12** WC **028158**

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 **Herrin**, on **August 7, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **October 11, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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

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

In the year preceding the injury, Petitioner earned $**54,973.00**; the average weekly wage was $**1,057.17**.

On the date of accident, Petitioner was **59** 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 $**6,267.93** for TTD, $- for TPD, $- for maintenance, and $- for other benefits, for a total credit of $**6,267.93**.

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

ORDER

Petitioner failed to prove she sustained an accident on July 18, 2012 that arose out of and in the course of her employment or that her current condition of ill-being is causally related to said accident.

Petitioner's claim for compensation is denied and no benefits are awarded.

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

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

Signature of Arbitrator

10/11/14
Date

OCT 20 2014

Terie Brewer v. Chester Mental Health Center
Case No. 12 WC 028158

Petitioner filed an application for adjustment of claim with the Illinois Workers' Compensation Commission. Petitioner alleged that she sustained injuries to her left shoulder as a result of lifting a trauma bag while working for Chester Mental Health Center. Petitioner has alleged the date of accident as July 18, 2012. The issues in dispute are accident, causal connection, medical bills, temporary total disability, credit for overpayment of temporary total disability, and nature and extent.

Respondent entered into evidence records from Dr. Jodi Buskohl, a chiropractor, which were received in compliance with a Subpoena. (RX10) The records indicate that Petitioner began treating with Dr. Buskhol in 2008. On the initial intake information, Petitioner indicated that she had current complaints of bilateral shoulder pain and she'd had shoulder pain for two years.

On May 8, 2012, Petitioner presented to her primary care doctor, Dr. Lisa Lowry-Rohlfing at Chester Clinic, for reevaluation of her chronic back/shoulder pain. (RX9) Petitioner reported to Dr. Lowry-Rohlfing that due to her shoulder pain, she had to supplement her fibromyalgia medication with Vicodin. She noted pain with range of motion, lifting, and any type of sitting or standing.

Petitioner presented to Dr. Buskohl with left shoulder complaints on July 11, 2012 and July 25, 2012 and received massages and adjustments.

On July 26, 2012, Petitioner presented to Dr. Lowry-Rohlfing, with complaints of left shoulder pain. She provided a history of four to six weeks of pain that was getting progressively worse. The pain was noted to be aggravated with movement. The pain awakened her at night. It was described as an achy pain in the left shoulder. Petitioner denied any acute injury. She was already on medication for her fibromyalgia pain and inquired about increasing the dosage for her current pain. Dr. Lowry-Rohlfing ordered an MRI of the left shoulder and temporarily increased her medication dosage.

The recommended MRI of the left shoulder was performed on July 30, 2012 and revealed a supraspinatus full-thickness tear extending from its anterior most attachment posteriorly 1.3 cm with 1.4 cm retraction. There was an associated muscle strain/partial tear at the supraspinatus myotendinous junction. It further revealed a supraspinatus, infraspinatus and long head of the biceps tendinopathy. Red marrow conversion indicated a hypoxic state of the body with differential considerations including smoking, obesity, and anemia.

On July 31, 2012, an Information Report was completed regarding a phone call from Petitioner. (RX4) When Petitioner called she stated that she had had problems with her shoulder for many years due to a bone spur in the shoulder. Recently she had had more pain in the shoulder so she

went to the doctor. An MRI was done. Petitioner advised that she had thought about how this happened, and believed that it happened several weeks ago while checking the trauma bags.

On August 1, 2012, Petitioner completed a Workers' Compensation Employee's Notice of Injury for a date of accident of July 18, 2012. (RX1) She noted that she did not report the injury on the date of accident as she thought it was "just a small strain, but did not get better so had MRI."

On August 2, 2012, Petitioner's supervisor, Jennifer Klingeman completed a Supervisor's Report of Injury or Illness. (RX2) Petitioner's supervisor noted that with regard to lifting the bag by herself, Petitioner stated, "Usually 2 of us do this together, but I was by myself." It was noted that Petitioner should not have lifted the bag without assistance, and that the "normal practice is 2 people do this together". Petitioner was counseled on the proper procedure of notification of an injury and lifting techniques.

Dr. Lowry-Rohlfing authored an addendum to the July 26, 2012 note on August 2, 2012. It was noted that "Terri phoned the office this morning about this MRI and states that she has recently recalled since our visit on the 26th that on July 18th she lifted a 150 pound trauma bag of IV bags and after lifting this bag is when he [sic] left shoulder started to feel sore. She states that she does this on a regular basis which is why she didn't recall it at our visit on 7/26/12". The addendum further noted that Petitioner's pain continually got worse after that incident so she made an appointment and is now filing a worker's comp claim. Petitioner was referred to Dr. James Michael Davis, an orthopedic surgeon at Orthopaedic Institute of Southern Illinois.

Petitioner presented to Dr. Davis on August 20, 2012 with complaints of constant, aching left shoulder pain. She provided a history of an injury on July 18, 2012 when she was lifting a trauma bag weighing about 150 pounds. After the accident, Petitioner reported that she felt a sharp, sudden pain. Dr. Davis reviewed the MRI and performed a physical examination, after which he diagnosed Petitioner with a left rotator cuff tear. He recommended surgical intervention in the form of a left open rotator cuff repair.

On October 2, 2012, Petitioner underwent an examination under anesthesia, open acromioplasty and arch decompression and open rotator cuff repair of the left shoulder.

Petitioner followed up with Dr. Davis on October 8, 2012. Dr. Davis ordered physical therapy that Petitioner completed at Sparta Community Hospital. Petitioner followed up with Dr. Davis again on November 5, 2012, December 10, 2012, January 21, 2013 and on April 29, 2013. At her last appointment with Dr. Davis on April 29, 2013, Dr. Davis placed Petitioner at MMI and released her from care. He advised that she may continue to gain strength. Petitioner was released with no restrictions.

Dr. Davis testified via evidence deposition on February 13, 2014. Dr. Davis opined within a reasonable degree of medical certainty he believed that Petitioner's work injury might or could have been a causative factor in bringing about her rotator cuff tear. He based this opinion on the

history provided by Petitioner, the MRI review, and intraoperative findings. Dr. Davis admitted that he had not reviewed any treatment records from any other physicians Petitioner had seen, specifically he had not reviewed records from Chester Clinic or Dr. Jodi Buskohl. On cross-examination, Dr. Davis agreed that it was important to have a full and accurate history of the accident in order to form a causation opinion, and that a nurse understand the importance of taking an accurate history and giving an accurate history to a medical professional. Dr. Davis was asked to review Petitioner's medical records from Chester Clinic dated May 8, 2012, July 26, 2012, and August 2, 2012. Dr. Davis was asked if the fact that he did not have an accurate history made it difficult to give a definitive causation opinion, and Dr. Davis stated "I think it's interesting timing. Have I seen it before? Yes. And I tend to go more by the patient's history that they give me, but I do find it interesting, yes."

Dr. Davis was asked on cross if he would expect a woman of Petitioner's age, height, weight, and physical condition would be able to pick up a 150 lb. bag from the floor to waist height, and Dr. Davis testified that he thought it would be difficult.

Dr. Davis testified that if the history of the accident was found to be inaccurate, then it could potentially change his causation opinion.

Dr. Davis agreed that a full thickness tear of the supraspinatus could be degenerative in nature. Dr. Davis further agreed that obesity, age, and smoking were all factor to a potentially degenerative condition of a tear of the supraspinatus.

Respondent had Petitioner evaluated by Dr. Michael Nogalski on September 23, 2013. (RX7) Dr. Nogalski testified via evidence deposition on March 24, 2014. (RX8). Petitioner provided a history to Dr. Nogalski that she was working in the health clinic by herself, and that she slung up a 150 pound disaster bag from the floor up onto one of the beds. She recalled that she did not feel a pop, but that it hurt at that time. Petitioner admitted to Dr. Nogalski to having shoulder problems in the past, including having to use a TENS unit approximately 10 times on her shoulder prior to July 18, 2012. She stated that after July 18, 2012, she had a lot more pain and could not really use her shoulder comfortably. Dr. Nogalski reviewed the records of Drs. Davis and Lowry-Rohlfing, as well as reports of the injury and a job description. Dr. Nogalski agreed with Dr. Davis's diagnosis of left shoulder rotator cuff tear. However, based on the historical documentation he reviewed, he opined that her condition of ill-being was not related to the accident of July 18, 2012. Specifically, Dr. Nogalski noted the differences in histories provided to him, versus the histories provided to Dr. Davis and Lowry-Rohlfing.

Petitioner is employed by Respondent as an RN. Petitioner testified that on July 18, 2012, she was lifting a disaster bag to an examination table to check expired medicine when she pulled her left shoulder. Petitioner testified that the disaster bag weighed between 100 and 150 pounds. She testified that the table was approximately two feet high. Petitioner testified on the date of the alleged accident she was on night shift and was working alone, and did not have anyone to

assist her in lifting the bag. She testified that she lifted the bag approximately one time per month since January of 2012, and had been lifting them by herself since that time. She admitted that she is not required to lift it up to inspect the contents, but that if she did not lift it she would have to bend over or sit on the floor and inspect the bag. Petitioner testified that she was not aware that it was against policy to lift that much weight by herself, and she denied having completed a body mechanics training class that advised her to have another person assist her with lifting that much weight.

Petitioner testified the time of the accident she did not have much benefit time or sick time available.

Petitioner testified that she had previous history or left shoulder complaints including a bone spur that was found in 2005. Petitioner admitted that in May of 2012, two months prior to the alleged accident, she presented to her primary care doctor with left shoulder complaints. Petitioner admitted that she did not mention a work injury at the July 26, 2012 visit because she thought it was her bone spur acting up or her fibromyalgia. She testified that she did not relate her condition at that time to anything because she had not done anything unusual. She did not recall lifting the trauma bag until after the MRI when her doctor said the tear would have been caused by something heavy.

Petitioner testified that she still suffers from complaints in her left shoulder, including the inability to carry heavy grocery bags, numbness and tingling, and generalized weakness. Petitioner testified that she takes Vicodin three or four times a month still for her left shoulder. Petitioner admitted that she has not followed up with Dr. Davis for these complaints, even though he directed her to do the same.

Jennifer Klingeman testified on behalf of the Respondent. She testified that she is employed at Chester Mental Health Center as the Director of Nursing. She testifies that she is Petitioner's supervisor. She testified that she authored Respondent's Exhibit 2 and 4 on August 2, 2012 and August 1, 2012, respectively.

Ms. Klingeman testified that she disagreed that Petitioner was not aware that the policy was to ask for assistance with lifting heavy objects. She testified that as nurses, they are all taught the proper body mechanics and to ask for assistance. Ms. Klingeman testified that Petitioner had completed a body mechanics training class. Ms. Klingeman further testified that she had never seen any of her staff lift the trauma bag to the table; customarily the nurses leave it on the ground to inspect the contents.

Ms. Klingeman also testified that Petitioner was not working alone that night or week, that there were two RN's scheduled to work in that area, that there were regularly scheduled staff to work in that area to perform that particular duty. Ms. Klingeman testified that "[o]ur policy states that we check the integrity of the bad. It does not state that we lift the bag monthly. So that's not in our policy or practice to do that".

Ms. Klingeman also testified that the Petitioner had reported to her that she had been babysitting her one-year-old granddaughter.

Therefore, the Arbitrator concludes the following:

1. Petitioner has failed to prove that she sustained an accident that arose out of and in the course of her employment with Respondent on July18, 2012. In addition, Petitioner has failed to prove that her current condition of ill-being in her left shoulder were a result of an alleged work related accident of July 18, 2012.

   "To obtain compensation under the Act, a claimant bears the burden of showing, by a preponderance of evidence, that he has suffered a disabling injury which arose out of and in the course of his employment." *Sisbro, Inc. v. Indus. Comm'n*, 207 Ill.2d 193, 203, 797 N.E.2d 665, 671 (2003). Preponderance of the evidence is "evidence which is of greater weight or more convincing than the evidence offered in opposition of it; it is evidence which as a whole shows that the fact to be proved is more probable than not." *Gonzales v. United Airlines, Inc.*, 03 IL.W.C. 30483, 09 I.W.C.C. 0458 (2009), citing *Jones v. J. Rubin Co,* 98 IL.W.C. 7779, 02 I.I.C. 0142 (2002). "Among the factors to be considered in determining whether a claimant has sufficiently carried his burden is his credibility." *Id.* At trial, a "witness' credibility is always in question." *Bish v.Guiseppe's Pizza*, 07 IL.W.C. 27341, 09 I.W.C.C. 0382 (2009). Credibility is the quality of a witness which renders his evidence worthy of belief. *Gonzales*. It is the Arbitrator's duty to evaluate a witness' credibility, as well as, "the witness's demeanor and internal and external inconsistencies in his testimony." *Id.*

   A claimant's testimony, "standing alone, may support an award where all of the facts and circumstances do not preponderate in favor of the opposite conclusion." *Sieber v. Indus. Comm'n*, 82 Ill.2d 87, 97, 411 N.E.2d 249 (1980). However, "when the claimant's testimony is virtually the only evidence favoring an award, and that testimony is repeatedly contradicted by the record, then it is this court's duty to disallow the claim." *Caterpillar Tractor Co. v. Indus. Comm'n*, 73 Ill.2d 311, 315, 383 N.E.2d 220, 222 (1978).

   The Petitioner's medical records belie her testimony that she suffered an injury occurring on July 18, 2012. It was not until Petitioner underwent an MRI and obtained the findings that she even related her chronic pain to her alleged accident at work. Petitioner testified that before then she believed her shoulder pain was related to her bone spur or fibromyalgia, but that after the MRI her doctor told her "it would have to be doing something that was heavy". However, there is nothing in the medical records to corroborate this testimony, in fact, the records indicate that she telephoned Dr. Lowry-Rohlfing on August 2, 2012 because she had just remembered lifting the trauma bag and that must have been what caused her shoulder pain.

Petitioner admitted she has a longstanding history of chronic left shoulder problems, and admitted she did not have much sick time to use at work.

The Arbitrator finds that in light of the many inconsistencies at issue in this case the Petitioner's testimony is less than credible. Therefore, the Petitioner has not met her burden of proving by a preponderance of the evidence that her injury arose out of and in the course of his employment.

2. Claim is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF LASALLE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Patricia Hopper,
Petitioner,

vs.
Department of Transportation,
Respondent,

NO: 10 WC 41725

15IWCC0655

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 temporary total disability, vocational rehabilitation, maintenance and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 5, 2015 is hereby affirmed and adopted.

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

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

No bond for State of Illinois cases.

DATED: AUG 21 2015

David L. Gore

Stephen Mathis

Mario Basurto

DG/mam
o:7/30/15
45

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

HOPPER, PATRICIA
Employee/Petitioner

Case# **10WC041725**

15IWCC0655

DEPARTMENT OF TRANSPORTATION
Employer/Respondent

On 1/5/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.13% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
MICHAEL A ROM
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

5120 ASSISTANT ATTORNEY GENERAL
DAVID PAEK
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1430 CENTRAL MGT SERVICES
201 E MADISON ST
SUITE 3C
SPRINGFIELD, IL 62794

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

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

JAN 5 - 2015

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

STATE OF ILLINOIS)
)SS.
COUNTY OF LaSalle)

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

15IWCC0655

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 19(B)

Patricia Hopper,
Employee/Petitioner

v.

Department of Transportation,
Employer/Respondent

Case # **10** WC **41725**

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 **11/26/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **7/15/10**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**62,968.50**; the average weekly wage was $**1,210.93**.

On the date of accident, Petitioner was **49** 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 $**158,580.35** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**158,580.35**.

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

ORDER

Respondent shall pay any outstanding medical fees relating to the treatment of the Petitioner's bilateral shoulders directly to the medical providers and subject to the medical fee schedule.

The Arbitrator awards the Petitioner TTD from October 27, 2010 through June 6, 2014. The Arbitrator awards Petitioner maintenance from June 7, 2014 through August 1, 2014. The Respondent shall be credited for payment of TTD/maintenance in the amount of $158,580.35.

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

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

Signature of Arbitrator

12/30/14
Date

JAN 5 - 2015

15IWCC0655

FINDINGS OF FACT

This case involves a Petitioner claiming a traumatic injury to her shoulders from her employment with the Illinois Department of Transportation ("IDOT"), with an alleged accident date of July 15, 2010. [Arb. Ex. 1.] The issues in dispute are: what were the Petitioner's earnings; and what temporary benefits are in dispute. [Id.]

The Petitioner testified that as of July 15, 2010, her alleged accident date, she was employed by the Illinois Department of Transportation, District 1, for the Bureau of Construction as an Engineering Technician IV. She had been an IDOT employee for 28 years and had previously held the Engineering Technician I, II and III positions, respectively. As an Engineering Technician IV, the Petitioner testified she would oversee construction projects which would require her to be on-site and actively involved with various aspects of projects including testing and inspecting.

On July 15, 2010, the Petitioner was in the process of moving into a field office provided by a construction contractor. The Petitioner testified that she was moving boxes, some of which contained books and concrete slab samples. She testified that some of these boxes weighed up to 50 pounds. While moving these boxes, the Petitioner testified she felt a twinge in her right shoulder. However, she continued to work.

The Petitioner filled out a notice of injury form on July 22, 2010. [RX 9.] She stated that she felt a pop in her right arm and that her right hand was going numb. [Id.]

On July 20, 2010, the Petitioner presented to the emergency room at Morris Hospital complaining of a right arm injury. [RX 4:9-11.] The Petitioner was diagnosed with a right bicep strain and given a splint. [Id.]

The Petitioner was subsequently referred to Dr. John Nikoleit, an orthopedic doctor. On September 1, 2010, Dr. Nikoleit's impression was a possible rotator cuff tear of the right shoulder. [RX 2:57.] He directed her to have an MRI of the right shoulder. [Id.]

On October 20, 2010, an MRI of the Petitioner's right shoulder indicated degenerative changes of the acromioclavicular joint with evidence of impingement. [RX 2:63.] Moderately large full thickness tear of the supraspinatus tendon with focal gap, fluid filled and abnormal fluid in the subacromial and subdeltoid bursa. [Id.] There is proximal tendon retraction. [Id.] The distal subscapularis tendon is attenuated and may also be torn, but there is no retraction demonstrated. [Id.] Labral evaluation limited with no definite tear identified. [Id.] Mild degenerative changes of the humeral head without evidence to suggest occult fracture or bone bruise. [Id.]

On October 27, 2010, Dr. Nikoleit discussed surgical repair of the Petitioner's right shoulder after reviewing the results of her right shoulder MRI. [RX 2:56.] On December 9, 2010, Dr. Nikoleit performed a right shoulder open acromioplasty and repair on the Petitioner. [RX 2:70-1.] Following her right shoulder surgery, the Petitioner received physical therapy over the span of 3-4 months. On April 15, 2011, the Petitioner presented to Dr. Nikoleit complaining of pain and discomfort in the right shoulder following a fall in February. [RX 2:47.] Dr. Nikoleit ordered a repeat MRI of the Petitioner's right shoulder. [Id.] On June 10, 2011, while awaiting approval for the MRI of the shoulder, the Petitioner presented to Dr. Nikoleit complaining of tenderness and pain in her right shoulder. [RX 2:45.] Dr. Nikoleit injected the Petitioner's right shoulder with 40 mg of Depo-Medrol to alleviate some of her pain. [Id.]

On July 8, 2011, an MRI of the Petitioner's right shoulder indicated a moderately large full thickness tear of the supraspinatus tendon with a large fluid filled gap, tendon retraction proximally and abnormal fluid in the

subacromial and subdeltoid bursa, and a probable additional tear of the subscapularis tendon. [RX 2:62.] On July 18, 2011, the Petitioner presented to Dr. Nikoleit. [RX 2:43.] Dr. Nikoleit confirmed a recurrent right rotator cuff tear and planned to proceed with surgical revision of rotator cuff repair. [Id.]

On August 12, 2911, the Petitioner presented to Dr. Nikoleit. She was awaiting approval for scheduling surgery on her right shoulder and complained that her left shoulder had been increasingly painful because of overuse. [Id.] She complained of achiness in her left shoulder and of pain with overhead activity and painful motion. [Id.] Dr. Nikoleit noted a positive impingement test and gave an impression of a left shoulder strain. [Id.]

On September 22, 2011, Dr. Nikoleit performed a right shoulder arthroscopy and open rotator cuff repair. [RX 2:68-9.] The Petitioner started physical therapy for her right shoulder in October 2011.

On December 2, 2011, the Petitioner presented to Dr. Nikoleit complaining of severe discomfort in the trapezius region of the right arm. [RX 2:37.] Dr. Nikoleit administered an injection to the tender area and instructed the Petitioner to continue therapy to strengthen the right arm. [Id.] The Petitioner also continued complaining of left shoulder problems and was awaiting approval for a cortisone injection to her left shoulder. [Id.]

On January 6, 2012, the Petitioner presented to Dr. Nikoleit complaining of discomfort and pain in the right shoulder. [RX 2:36.] Dr. Nikoleit administered an injection to the subacromial space. [Id.]

On March 2, 2012, the Petitioner presented to Dr. Nikoleit complaining of right shoulder pain. [RX2:34.] Dr. Nikoleit ordered a repeat MRI of the right shoulder and of her cervical spine. [Id.]

On March 30, 2012, the Petitioner presented to Dr. Nikoleit complaining of right shoulder discomfort. [RX 2:33.] Dr. Nikoleit also noted signs of impingement in the Petitioner's left shoulder. [Id.] He injected the Petitioner's left shoulder. [Id.]

On April 30, 2012, an MRI of the Petitioner's right shoulder indicated postoperative changes at the right shoulder consistent with previous partial acromioplasty and rotator cuff repair. [RX 2:60.] There was also indication of a full thickness tear of the supraspinatus tendon. [Id.] An intact subscapularis was not definitely visualized. [Id.]

On May 4, 2012, the Petitioner presented to Dr. Nikoleit. [RX 2:32.] Dr. Nikoleit confirmed a recurrent tear, small focal gap in the Petitioner's right shoulder. [Id.] The Petitioner was more concerned with her left shoulder pain and Dr. Nikoleit ordered an MRI of her left shoulder. [Id.]

On July 27, 2012, the Petitioner presented to Dr. Nikoleit complaining of pain in both of her shoulders. [RX 2:29.] Dr. Nikoleit administered a trigger point injection to the Petitioner's right shoulder. [Id.]

On August 31, 2012, the Petitioner presented to Dr. Nikoleit for bilateral shoulder pain. [PX 4.] Dr. Nikoleit assessed the Petitioner with right trapezius trigger point and spasm, and impingement in the left rotator cuff with a possible tear. [Id.]

On October 4, 2012, an MRI of the Petitioner's left shoulder indicated: partial articular surface tearing of the distal 1.5 cm of the supraspinatus tendon with a high grade fissure-like component just posterior to the rotator interval which is probably near complete or less likely a pinhole size complete defect; AC joint degenerative arthrosis with type II acromion narrowing supraspinatus outlet; suboptimal evaluation of longhead biceps tendon; and technically limited related to body habitus. [RX 2:59.]

On November 2, 2012, the Petitioner presented to Dr. Nikoleit. [RX 2:24.] Dr. Nikoleit recommended the Petitioner go to a pain clinic for her right shoulder pain symptoms and would await approval to schedule the Petitioner's left rotator cuff repair on the left shoulder. [Id.]

On January 9, 2013, the Petitioner submitted to an IME at the request of the Respondent. [RX 5.] Dr. Gregory Nicholson of Midwest Orthopaedics at RUSH opined that the Petitioner did not require further surgical intervention in her right shoulder. [Id.] He noted impingement and long head of biceps tendinitis and rotator cuff tendinosis in the Petitioner's left upper extremity. [Id.] Dr. Nicholson did find the Petitioner's left shoulder injury was indirectly related to her right shoulder condition and opined it was work-related. [Id.] Dr. Nicholson opined that the Petitioner had reached MMI as to the right shoulder and recommended a cortisone injection and physical therapy for the left upper extremity. [Id.]

On March 21, 2013, Dr. Nikoleit performed a left shoulder arthroscopy, intra-articular debridement of labral fraying and biceps tendinopathy, open rotator cuff repair, acromioplasty and distal clavicle resection on the Petitioner. [RX 2:65-7.] The Petitioner's postoperative diagnosis was left shoulder labral fraying and rotator cuff tear and biceps tendinopathy. Rotator cuff tear and AC joint arthrosis. [Id.] The Petitioner subsequently started physical therapy for her left shoulder.

On June 28, 2013, the Petitioner presented to Dr. Nikoleit still complaining of pain in her left shoulder. [RX 2:13.] Dr. Nikoliet prescribed her a Medrol Dosepak and instructed her to continue with physical therapy. [Id.] On July 26, 2013, the Petitioner presented to Dr. Nikoleit still complaining of left shoulder pain. [RX 2:12.] Dr. Nikoleit ordered a repeat MRI of the left shoulder. [Id.]

On August 20, 2013, while awaiting approval for a left shoulder MRI, Dr. Nikoleit injected the subacromial space of the Petitioner's left shoulder. [RX 2:11.]

On November 8, 2013, Dr. Nikoleit gave the Petitioner a refill on a Medrol Dosepak to decrease inflammation in her left shoulder. [RX 2:9.]

On December 18, 2013, the Petitioner submitted to a second IME performed by Dr. Nicholson. [RX 6.] Dr. Nicholson opined that no further recovery for her left shoulder could be anticipated and that the Petitioner had reached MMI as to both shoulders. [Id.] Dr. Nicholson acknowledged that the Petitioner would have permanent physical restrictions and recommended an FCE to determine the Petitioner's physical restrictions. [Id.]

On March 14, 2014, a repeat MRI of the Petitioner's left shoulder indicated: postoperative changes; resection of distal clavicle; tear of the anterior fibers of the rotator cuff tendon with retraction; some atrophy of the supraspinatus muscle; chronic irregularity of the glenoid labrum secondary to tear/degeneration or postoperative change; and degenerative changes about the humeral head. [RX 2:58.]

On April 25, 2014, the Petitioner presented to Dr. Nikoleit, who confirmed a left torn rotator cuff. The Petitioner did not wish to pursue revision rotator cuff repair and wanted to have an FCE. [RX 2:4.]

On June 6, 2014, the Petitioner had an FCE by Michelle Miller and Eric Saxton of Champion Fitness Physical Therapy. [RX 10.] The FCE indicated that "[t]he worker should be able to function at least at levels identified in the Medium work demand level/at levels listed in the summary table below with limitations as listed." [Id. at 2.] The FCE listed the following limitations for the Petitioner: 1. Material handlings: Occasional floor to waist 25#, waist to SH 25#, SH to OH 15#, carry 25#, pushing 40#, pulling 28#. Frequent floor to waist 25#, waist to

SH 15#, SH to OH 15#, carry not recommended, pushing 20#, pulling 14#. Constant floor to waist 12.5#, waist to SH 7.5#, SH to OH 7.5#, carry not recommended. 2. Non-Material Handling: Occasional: squatting, reaching, climbing, kneeling, crawling. Frequent: standing, walking, bending, grip/fine motor. Constant: sitting. [Id.]

On June 13, 2014, the Petitioner presented to Dr. Nikoleit. [RX 2:3.] Dr. Nikoleit acknowledged that the FCE put the Petitioner at a medium demand level. [Id.] Dr. Nikoleit released the Petitioner to work by June 23, 2014 within her restrictions. [Id.]

On August 1, 2014, the Petitioner presented to Dr. Nikoleit for a final visit. Dr. Nikoleit instructed her to continue to work within the same permanent restrictions. [RX 2:2.]

On October 7, 2010, the Petitioner was fired for cause from her position as an Engineering Technican IV from IDOT following an investigation conducted by the Office of the Executive Inspector General ("OEIG"). [See RX 7 and 8.] The OEIG determined that allegations that the Petitioner had abused State time by not working during her scheduled work hours and misused her assigned State vehicle by permitting her daughter to drive the State vehicle were founded. [RX 8.]

The Petitioner testified that she has conducted a self-directed job search but has been unsuccessful in finding a new job within her permanent physical restrictions as set by her FCE. Her job search efforts are supported by her job search log and correspondence to potential employers. [PX 8.] The Respondent has not offered to provide any vocational rehabilitation services to the Petitioner. The Petitioner testified that she would like to receive vocational rehabilitation from the Respondent.

With regard to TTD, the parties have stipulated to TTD/maintenance having been paid from October 27, 2010 through August 1, 2014 (the last date on which the Petitioner visited Dr. Nikoleit) in the amount of $158,580.35. [RX 11.]

With regard to any outstanding medical fees, the Respondent has agreed to pay any necessary and reasonable medical fees for treatment provided to the Petitioner directly to providers and pursuant to the fee schedule. [See PX 9.]

The Respondent called Georgina Syas to testify on its behalf. Ms. Syas testified she is the Personnel Services Manager for IDOT District 1. Ms. Syas attempted to testify that within IDOT there are positions available that the Petitioner could work within her permanent physical restrictions but for her for cause termination. To forego having to go through specific positions [see RX 12 and 13], the parties stipulated to IDOT having positions available within the Petitioner's permanent restrictions which she could have taken had she not been terminated for cause.

CONCLUSIONS OF LAW

1. With regard to the Petitioner's earnings, the parties have agreed to the Petitioner's earnings during the year preceding her injury being $62,968.50, and the average weekly wage being $1,210.93.

2. With regard to what temporary benefits are in dispute, the Arbitrator finds that the Petitioner is entitled to and hereby awards TTD from October 27, 2010 through June 6, 2014. The Arbitrator finds that the Petitioner is entitled to and hereby awards maintenance from June 7, 2014 through August 1, 2014. The Respondent shall be credited for payment of TTD/maintenance in the amount of $158,580.35. [RX 11.]

With regard to maintenance and vocational rehabilitation, the Arbitrator notes that this is an issue of first impression where the Petitioner is requesting maintenance and vocational rehabilitation from the Respondent and was terminated for cause by the Respondent. Had the Petitioner not been terminated for cause, her permanent physical restrictions could have been accommodated by the Respondent in one of the Respondent's available positions as stipulated by the parties. This case is distinguished from Interstate Scaffolding v The Illinois Workers' Compensation Commission, 236 IL 2nd 132, 923 N.E. 2d 266, 337 Ill. Dec. 707 (2010), which held that an injured employee who has not reached maximum medical improvement, is entitled to TTD benefits despite that employee's employment termination. In the present case, the Petitioner has reached MMI and testified that she is not seeking any additional medical treatment. And but for the fact that the Petitioner's employment with the State of Illinois was terminated for acts of dishonesty against the State of Illinois, Petitioner would have been able to continue working in her previous job or could have been accommodated, as indicated by the State's witness, Ms. Syas. Accordingly, the Arbitrator denies Petitioner's request for maintenance benefits and for vocational rehabilitation.

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Janice Norwood,
Petitioner,
vs.
University of Illinois,
Respondent,

NO: 11 WC 20561
15IWCC0656

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, medical, prospective medical, causal connection, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 is hereby affirmed and adopted.

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

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

No bond or summons for State of Illinois cases.

DATED: AUG 21 2015

David L. Gore

Mario Basurto

Stephen Mathis

DG/mam
o:7/30/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

NORWOOD, JANICE
Employee/Petitioner

Case# **11WC020561**

15IWCC0656

UNIVERSITY OF ILLINOIS
Employer/Respondent

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0320 LANNON LANNON & BARR LTD
MICHAEL S ROLENC
180 N LASALLE ST SUITE 3050
CHICAGO, IL 60601

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

1408 HEYL ROYSTER VOELKER & ALLEN
BRAD ANTONOCCI
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

0902 UNIVERSITY OF IL/CLAIMS MGMT
CHUCK HUTCHISON
1737 W POLK ST M/C 940 STE B
CHICAGO, IL 60612

0904 STATE UNIVERSITY RETIREMENT SYS
PO BOX 2710 STATION A*
CHAMPAIGN, IL 61825

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

JAN 27 2014

KIMBERLY B. JANAS Secretary
Illinois Workers' Compensation Commission

15IWCC0656

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Janice Norwood
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # **11** WC **20561**

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 **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Chicago**, on **October 23, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0656

FINDINGS

On **January 24, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** given to Respondent as explained *infra*.

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

In the year preceding the injury, Petitioner earned **$30,846.40**; the average weekly wage was **$593.20**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **2** dependent children.

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

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

Respondent shall be given a credit 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 **$12,913.54** under Section 8(j) of the Act. *See* AX1.

ORDER

Medical Benefits

Respondent shall pay reasonable and necessary medical services for bills submitted into evidence, pursuant to the medical fee schedule, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $12,913.54 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.

Permanent Partial Disability: Person as a whole

Respondent shall pay Petitioner permanent partial disability benefits of $355.92/week for 15 weeks, because the injuries sustained caused the 3% 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

January 20, 2014
Date

JAN 27 2014

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Janice Norwood
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

15IWCC0656

Case # **11** WC **20561**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing are accident, notice, causal connection, Respondent's liability for certain unpaid medical bills, and the nature and extent of Petitioner's injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that she was employed by Respondent in January 2011 as a payroll specialist II and she had been so employed for 10 years. Her job duties were to ensure that employees got paid and she performed some human resources functions as well. Petitioner testified that she had no problems with her back or hips before this injury and that she had no re-injury since this accident.

On cross examination, Petitioner acknowledged a prior workers' compensation claim for a left leg and back injury in January of 2002 when she fell in a building that was being remodeled. Petitioner testified that she only underwent physical therapy for this injury and that she saw a doctor at the University of Illinois, but she did not recall her diagnosis. Petitioner also testified that she injured her right hip in July of 2010 while dancing after which she saw a doctor and received pain medication.

On January 24, 2011, Petitioner testified that she started work at 9:00 a.m. and her shift ended at 5:00 p.m. She reported to the 7th floor of the student center east building in which she worked. Petitioner left work at 4:30 p.m. because her department altered her schedule so she could attend school. Petitioner went to the time clock on the same floor to punch out. Then, Petitioner took an elevator from the 7th floor to the 2nd floor then walked down a corridor and took the escalator down to the first floor where the bookstore and customer service desk are located to then exit the building.

Petitioner testified that the brick floor was really slippery and slick; it had just started snowing and there was water on the floor from people's shoes. She testified that, although the floor was wet, there were no rugs or cones down on the floor. Petitioner also testified that she was wearing a pair of flat, black leather shoes with rubber soles. She could see the customer service area and bookstore from where she fell and that she fell in the middle where there was pedestrian traffic.

Petitioner also testified that she was there because that was the building in which she worked and it was the closest to the parking lot where she is assigned. There are two sets of doors that she can use to then cross the

[1] The Arbitrator similarly references the parties' exhibits herein. Petitioner's exhibits are denominated "PX" and Respondent's exhibits are denominated "RX" with a corresponding number as identified by each party.

street to go into the employee parking lot to which she was assigned by the university's parking facility office. Petitioner testified that this parking lot is sometimes open to the public when there are events or conferences with students or others being given special parking for the event.

Petitioner testified that, while walking in this lobby area of the building, she slipped and fell. Her feet went up in air and she fell real hard on her bottom causing her a lot of pain. She also testified that her buttocks and whole body hit the floor, and that she hit the floor with her back. Petitioner added that people ran toward her and tried to get her up, but she could not do so. Petitioner specifically noticed pain in her hips and back. She testified that she was on her way to school at Chicago State University, but she was in so much pain that she told her teacher that she had to leave.

On cross examination, Petitioner testified that she fell at 4:35 p.m. and acknowledged that she had punched out from her work and that she was on her way to a class that was not required as part of her employment with Respondent, but that would benefit Respondent nonetheless once she obtained her higher degree. Petitioner also acknowledged that the area in which she slipped was open to the general public, not just employees.

Petitioner testified that she went into work the following day and reported the incident to Paula Lang ("Ms. Lang") the minute she got into work at 9:00 a.m. She testified that she told Ms. Lang and a higher supervisor what happened, and that she made a written report to Ms. Lang. On cross examination, Petitioner testified that the report of injury she signed on January 25, 2011 does not indicate that she slipped on something wet or whether she noted a defect in the floor. On re-direct examination Petitioner testified that she did tell Ms. Lang, however, that she slipped on water.

Petitioner testified that she was still in pain on January 28, 2011. She was coming in late to work and testified that she was told by her department that there would come a point where she would be written up.

Medical Treatment

Petitioner testified that she was sent to the employee health services department located on the west side of campus where she told the doctors that she slipped and fell. Petitioner added that she did not have money for emergency room care, so they made an appointment for her to undergo an MRI.

The medical records reflect that Petitioner reported to University Health Services on January 28, 2011 where she reported a fall at work four days earlier. PX1. She experienced sciatic pain in both legs, low back pain, inability to urinate, muscle soreness, and stiffness. *Id.* Petitioner followed up with Dr. Sidani on February 17, 2011. *Id.* He noted that Petitioner had a history of chronic right hip pain and obesity, but presented for new left hip pain and reported a mechanical fall last week with persistent left hip pain. *Id.* He ordered bilateral hip x-rays given her fall. *Id.* Petitioner underwent the recommended x-rays on the same day which showed mild degenerative joint disease in both hips and no acute dislocation or fracture. *Id.* Petitioner continued to undergo conservative medical treatment through April 3, 2012 at the University of Illinois and underwent physical therapy as ordered. PX1-PX2.

On March 29, 2011, Petitioner reported right hip and low back pain radiating down her leg into her ankle with worse pain in the morning. *Id.* Petitioner reported that it takes her a long time to work out the stiffness and pain from the night before. *Id.*

On April 22, 2011, Petitioner underwent a lumbar MRI which revealed moderate degenerative changes of the lower lumbar spine at L4-L5 and L5-S1 with grade 1 spondylolisthesis at L4-L5. *Id.*

Petitioner returned for a follow-up visit on May 10, 2011 for a reading on the MRI and for further follow up on July 26, 2011. *Id.* At that time, Petitioner reported that she had not had any relief from her pain since her fall. *Id.* The note also reflects that Petitioner was consistently using her FMLA as she was arriving late to work, which she stated was necessary to get mobile in the mornings. *Id.* Petitioner was diagnosed with a low back strain/sciatic nerve pain and referred for a neurology consultation. *Id.*

An August 8, 2011 physical therapy note reflects that Petitioner reported feeling great after her recent physical therapy visit, but had aggravated her symptoms after attending two weddings and moving apartments. PX2. Petitioner denied these reports during cross-examination.

On August 23, 2011, Petitioner returned to the clinic advising that the physical therapy was providing some pain control. PX1. An additional six weeks of physical therapy was ordered. *Id.*

On September 26, 2011, Petitioner saw a neurologist and complained of pain in her hips, right knee and back pain. *Id.* She was noted to have "hip back prior to accident - twisted something at a party 2009 had PT for it[.]" *Id.* The neurologist determined that Petitioner had a normal neurological exam and no evidence of significant lumbar radiculopathy. *Id.* He also indicated the Petitioner's lower back pain was likely due to mild degenerative joint disease and spondylolisthesis at L4-L5, diagnosed Petitioner with questionable arthritis in the knee, and mild hip arthritis/bursitis. *Id.* She was counseled on weight loss and referred to an ortho for her knee and hip. *Id.*

On November 1, 2011, Petitioner reported continued back, knee and hip pain. *Id.* She was diagnosed with osteoarthritis of the bilateral hips and likely right knee osteoarthritis. *Id.* Petitioner was referred for physical therapy with hydrotherapy. *Id.*

Petitioner underwent a second round of physical therapy at Maximum Rehabilitation from February 6, 2012 through February 22, 2012 when she was discharged to a home-exercise program. PX2.

At Petitioner's final doctor's appointment on April 3, 2012 she was still complaining of low back and hip pain bilaterally. *Id.* She also reported nightly pain and being unable to get out of bed in time to get to the restroom. *Id.* At this visit, Petitioner was diagnosed with degenerative disc disease in her lumbar spine with ongoing pain, bilateral hip osteoarthritis, obesity and urinary incontinence. *Id.*

Petitioner testified that, throughout her medical treatment, she experienced severe back and hip pain and pain running down her legs. Petitioner has had no medical treatment after April and no further medical treatment was recommended.

Additional Information

Regarding her current condition, Petitioner testified that she is still in pain every day and that she wears Depends at night because it is hard for her to get up out of the bed. She also testified that she has to get up 4-6 times during day to move her body around and that she takes high volume of pain killers for pain in her back and hips. Petitioner testified that she sits in a more open chair now with cushions, but after approximately 1½ hours she experiences more pain so she gets up and walks around.

On cross examination, Petitioner testified that she cannot walk long distances like she used to, she is slow going up and down stairs, she cannot engage in strenuous activities or work out, and that she rides in a cart while shopping in grocery stores. She acknowledged that she is currently working her regular, full duty job.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issue (C), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

"An employee's injury is compensable under the Act only if it arises out of and in the course of the employment." *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011).

Where an "employee is exposed to a risk common to the general public to a greater degree than other persons, the accidental injury is also said to arise out of his employment." *Id.* That is, a claimant must demonstrate that the risk of injury was peculiar to or increased by his work duties and the "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*, 407 Ill. App. 3d at 1014 (*citations* omitted). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that his injury is compensable. *University of Illinois*, 365 Ill. App. 3d at 910.

After careful observation of Petitioner and in consideration of all the evidence submitted at trial, the Arbitrator finds Petitioner's testimony to be credible. The record reflects that Petitioner was traversing Respondent's lobby in the building in which she worked when she fell. Petitioner reported the accident orally and in writing the following day to her supervisor and another higher level supervisor. No evidence was offered in contravention of Petitioner's testimony about the details of her accident. To the contrary, Petitioner's testimony about her injury is buttressed by the written report of injury that she completed on January 25, 2011 about which she testified at trial.

Moreover, the Arbitrator finds that Petitioner's risk of injury in the lobby, which was undeniably open to members of the public, was increased as a result of her employment. She walked through that lobby minutes after she punched out taking the usual and most direct route to exit the building toward her car which was located in a parking lot assigned to her by Respondent. Indeed, Petitioner was required to walk through this particular lobby to leave work every day placing her at a greater risk than members of the general public.

Based on all of the foregoing, the Arbitrator finds that Petitioner sustained an accident that arose out of and in the course of her employment with Respondent as claimed.

15IWCC0656

In support of the Arbitrator's decision relating to Issue (E), whether timely notice of the accident given to Respondent, the Arbitrator finds the following:

Notice of an accident shall give the approximate date and place of the accident, if known, and may be given orally or in writing, but not later than 45 days after the accident with some very limited exceptions. 820 ILCS 305/6(c). The purpose of the notice requirement is to enable an employer to investigate an alleged accident. *Seiber v. Industrial Comm'n*, 82 Ill. 2d 87, 95 (1980). A claimant's compliance with the notice requirement is established by placing the employer in possession of the known facts related to the accident within the statutory period. *Seiber*, 82 Ill. 2d at 95. "Because the legislature has mandated a liberal construction on the issue of notice [citation] if some notice has been given, although inaccurate or defective, then the employer must show that he has been unduly prejudiced." *Gano Electric Contracting v. Industrial Comm'n*, 260 Ill. App. 3d 92, 96 (4th Dist. 1994). A claim is barred only if no notice whatsoever has been given. *Id.*

In this case, Petitioner testified that she verbally reported her injury the day following her accident to Ms. Lang and another supervisor. The record also reflects that Petitioner completed a report of injury dated January 25, 2011 corroborating Petitioner's testimony that she completed an accident report after speaking with Ms. Lang. Based on the foregoing, the Arbitrator finds that Petitioner has established that she provided proper and timely notice of her alleged accident at work to Respondent.

In support of the Arbitrator's decision relating to Issue (F), whether the Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

As explained above, the Arbitrator finds that Petitioner sustained a compensable injury as claimed. Again, the Arbitrator finds that Petitioner's testimony at trial was credible and corroborated by the medical records. Thus, the Arbitrator finds that Petitioner has established a causal connection between her current condition of ill being and accident at work.

In support of the Arbitrator's decision relating to 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 the following:

As explained above, the issues of accident, notice and causation have been resolved in Petitioner's favor. Moreover, the medical records submitted into evidence corroborate Petitioner's testimony that the conservative medical treatment that she received was to treat her for the pain and symptoms she experienced after her fall at work. Thus, the Arbitrator awards the medical bills incurred by Petitioner and submitted as exhibits into evidence to be paid by Respondent as provided in Sections 8(a) and 8.2 of the Act.

In support of the Arbitrator's decision relating to Issue (L), the nature and extent of Petitioner's injury, the Arbitrator finds the following:

Based on the record as a whole—which reflects conservative medical treatment to the low back and left hip for a strain that aggravated Petitioner's underlying degenerative conditions with some continued symptomatology, but no lost time from work or medical restrictions—the Arbitrator finds that Petitioner has established permanent partial disability to the extent of 3% loss of use of the person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

MICHAEL SHEA,

Petitioner,

15IWCC0657

vs.

NO: 11 WC 20607

RPRD DYCHMAN, INC.,

Respondent.

DECISION AND OPINION ON REMAND

This cause comes to the Commission on remand from the Circuit Court of Coles County after Respondent's appeal to the Appellate Court was dismissed. Initially, the Arbitrator found that Petitioner failed to sustain his burden of proving a work-related mental-mental accident/injury on October 2, 2010 and denied compensation. Petitioner sought review of that decision and the Commission affirmed and adopted the Decision of the Arbitrator on November 7, 2013.

The Circuit Court of Coles County reversed the Decision of the Commission. The order of the Circuit Court provided to the Commission only states that the case is remanded to the Commission "for entry of an award of compensation including temporary total disability and a permanency award." The Circuit Court provided no additional explanation or guidance.

Findings of Fact and Conclusions of Law

1. Petitioner was a cross country truck driver. He testified on October 2, 2010, during a trip between St. Louis and Champaign, he witnessed the aftermath of an accident in which an automobile driver was killed. Petitioner testified that he saw a body of a man lying on the pavement with part of his skull missing; "he was obviously dead." Petitioner claims that this scene caused him a mental-mental injury which resulted in post-traumatic stress syndrome ("PTSD") and thereafter he was unable to drive a truck professionally.

15IWCC0657

2. Petitioner also testified he had three years of college education, and was previously in the active military for 21 years primarily in aviation maintenance. The record also indicates he also flew a helicopter in operation Desert Storm.

3. Respondent gave Petitioner another assignment about six days after he witnessed the accident. Petitioner testified the "shock and horror still hadn't worn off" but he "really felt" that he "had to stay with it." On that assignment he drove back and forth from St. Louis to Kansas City.

4. The prominent thing Petitioner remembered after his trip to Kansas City was the inability to sleep. It was nothing for him "to stay up all night and go to bed, sleep a couple of hours and then get back up." That problem continues from "time to time." He has become "pretty irritable, agitated." He thought he alienated a lot of his friends and family members. He has difficulty concentrating and does not "have any desire to watch any trucking programs or anything that involved, you know, misfortune, death, anything like that." Petitioner eventually sought treatment from Dr. Lipsitz, a psychologist referred to him by his general practitioner. He declined medication because it resulted in possible side-effects of sedation and loss of motor skills.

5. Petitioner stated he sought other employment as soon as he was 'released" by Respondent. Within the past couple of months he applied to "probably at least a dozen places." He had an interview with Home Depot, but nothing came of that. He worked for a janitorial service for less than a week. He also got temporary seasonal work at Wal-Mart. In 2010 he explored "probably 50 to 75 different possibilities." That search included truck driving, but not necessarily driving a bid truck. He has not been offered any job driving non-semi trucks. Petitioner tried to make money in photography, but realized he was losing money in the endeavor.

6. Petitioner further testified that since he was diagnosed with PTSD he would need medical clearance to operate a commercial motor vehicle. He had no such clearance. Petitioner testified he still thinks about the incident and when he is "idle, that's nighttime, it can recur." He gets agitated and cannot sleep; he'll get out of bed several times a night. He would watch TV or go on the internet to distract himself.

7. On cross examination, Petitioner acknowledged that driver logs indicate that his assignment for Respondent after the incident was from St. Louis to Champaign. He agreed that he probably took the same route as he did on the night of the incident. While his CDL was current his medical certificate wasn't. He hadn't tried to renew his medical certificate because it was senseless because he did not have a commercial driving job.

8. Petitioner agreed he was not aware of the side-effects of medication until he read Respondent's Section 12 medical examiner, Dr. Bassett's, deposition. He did not ask Respondent to provide psychological treatment. He agreed that before he saw Dr. Lipsitz he consulted a lawyer about a civil action against the driver that caused the accident because he felt he "had been totally abandoned in this whole process."

9. Petitioner's general practitioner suggested he treat with a psychologist, but he did not refer Petitioner to Dr. Lipsitz specifically. He probably discussed getting psychological treatment about two weeks prior to seeing his general practitioner. Petitioner told Mr. Dychman he still wanted to drive trucks for Respondent after he was suspended, "until a point that [he] probably couldn't;" he needed the income. He received minimum wage in a janitorial job mostly cleaning movie theaters. He quit that job because of a disagreement with a co-worker.

10. Robert Dychman, a principal of Respondent, testified he became aware Petitioner was involved in an accident on October 2, 2010 when Petitioner called him at about 1 am. He got to the scene at about 3:30 am. He communicated with Petitioner "quite a bit," while they were waiting for the state police to complete their investigation. He drove the semi to a Wal-Mart at the next exit and made arrangements for it to be towed to Effingham. Petitioner took the witness' car and followed him. They drove to St. Louis together. There, Petitioner drove home in his own car.

11. Mr. Dychman also testified he discussed the accident with Petition on the way to St. Louis; Petitioner was shaken and concerned, but he was not hysterical. He was not crying or literally physically shaking. He did not appear to be in shock. His responses to the witness' questions were appropriate. The entity that contracted with Respondent would not allow Petitioner to drive because the drug tests administered by the state would not be available for 30 to 60 days. The witness argued with the contracting company to get the matter resolved, and that discussion resulted in the post-accident assignment Petitioner was given. That run was between Springfield and Champaign. Petitioner told him that he used the same route as on the night of the incident.

12. Petitioner never told Mr. Dychman he was unable to work as a truck driver after the incident. He believed he first discussed a workers' compensation claim with Petitioner on May 5, 2011. Petitioner called him as a courtesy to let him know that he talked to a lawyer. The lawyer did not think a civil action would be fruitful and that he was going to see a psychological doctor and possibly file a workers' compensation claim. Petitioner did not tell him he had already seen a doctor but intended to.

13. On cross examination, Mr. Dychman reiterated the run Petitioner had after the incident was from St. Louis to Champaign. Petitioner felt "weird" about going through the scene of the accident. Petitioner had been a good employee. However, there "there were some issues."

14. Vocational rehabilitation counselor, Stephen Nolan, testified by deposition on May 24, 2012. He noted that Petitioner's PTSD precluded him from commercial driving positions. Petitioner had worked as a buyer for employers in the past, but that was a long time ago and he had no current skills as a buyer. Petitioner was only suited for "unskilled jobs that would be typically low paying jobs." He thought the salary range would be the current minimum wage to a couple of dollars more an hour.

15IWCC0657

The Circuit Court reversed the Commission decision affirming the Decision of the Arbitrator. Therefore, the Circuit Court apparently found that Petitioner suffered a mental-mental injury resulting from the October 2, 2010 incident. Pursuant to the mandate of the Circuit Court, the Commission is required to accept that finding and to award temporary total disability and permanency.

Petitioner seeks temporary total disability benefits for 32 weeks between the date of accident, which he inaccurately cited as October 27, 2010, to June 9, 2011, the date Dr. Basset declared him to be at maximum medical improvement. The Commission notes that Petitioner performed a post-accident truck run for Respondent ending on October 9, 2010. Therefore, we begin temporary total disability benefits as of that date. Accordingly, the Commission awards temporary total disability benefits from October 9, 2010 through June 8, 2011, for a total of 34&5/8 weeks.

Petitioner seeks a wage differential of $241.71 based on the testimony of Mr. Nolan that Petitioner could earn only a little more than minimum wage. Petitioner used the hourly wage of $9.00 in his calculation. In the alternative, Petitioner was "prepared to accept" an award of 35% loss of the person as a whole.

The Commission finds that a wage differential award is not appropriate here. Petitioner did not adequately prove the extent of any diminution of his earning potential because he did not provide evidence of a *bona fide* and vigorous job search. In addition, the Commission finds the opinion testimony of Mr. Nolan, the vocational rehabilitation counselor, flawed because he did not ascribe any value to Petitioner's extensive experience in the military, his extensive experience as a mechanic, and his three years of higher education.

In the claim now before the Commission, we note that Petitioner declined medication to treat PTSD apparently before he learned of the side-effects. Such declination would suggest that Petitioner does not consider his condition to be extremely debilitating. In addition, even if Petitioner is precluded from driving a large truck cross country, given his extensive military experience, mechanical experience, and relatively high level of education, Petitioner should be employable in a job with similar earning potential to his previous job. The Commission notes that the Decision of the Arbitrator indicated his income the previous year was $31,288.92 and his average weekly wage was $601.71.

The Commission notes that two recent claims involving PTSD are instructive on the issue of the nature and extent of Petitioner's permanent disability. In, *CTA v. IWCC,* 989 N.E.2d 608 (1st Dist 2013), a CTA bus driver was involved in an accident in which the bus she was driving killed a pedestrian. After compensability was determined by the Appellate Court, the claim was settled for 4% loss of the person as a whole. In *Diaz v. IWCC*, (App. Ct. 2nd Dist. 2013) 120294 WC, a policeman was confronted by an assailant with what turned out to be a toy gun. After compensability was determined by the Appellate Court, the Commission awarded the claimant 7.5% of the person as a whole. In looking at the record before us as a whole, the Commission finds that a permanent partial disability award of 25 weeks representing 5% loss of the person as a whole is appropriate in this case.

15IWCC0657

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $401.14 per week for a period of 34&5/8 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $361.03 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 5% of the person as a whole.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $23,000.00. The party commencing the proceeding for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in the Circuit Court.

DATED: AUG 2 4 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
O-8/12/15
46

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0658

Laura Patino,
Petitioner,
vs.

NO: 11 WC 2690

Transilwrap Company,
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, medical, temporary total disability, permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed May 21, 2014 is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,200.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 24 2015
KWL/vf
O-8/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0658

PATINO, LAURA
Employee/Petitioner

Case# **11WC002690**

TRANSILWRAP COMPANY INC
Employer/Respondent

On 5/21/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2553 LAW OFFICE OF JAMES P McHARGUE
BRENTON M SCHMITZ
123 W MADISON ST SUITE 1000
CHICAGO, IL 60602

0766 HENNESSY & ROACH PC
AUKSE R GRIGALIUNAS
140 S DEARBORN ST 7TH FL
CHICAGO, IL 60603

STATE OF ILLINOIS)
)SS.
COUNTY OF Cook)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION **15IWCC0658**

Laura Patino
Employee/Petitioner

v.

Transilwrap Company, Inc.
Employer/Respondent

Case # 11 WC 02690

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 **Deborah L. Simpson**, Arbitrator of the Commission, in the city of **Chicago**, on **May 5, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **December 16, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**19,916.00**; the average weekly wage was $**383.00**.

On the date of accident, Petitioner was **38** years of age, ***married*** 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.

ORDER

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$286.00/week** for **30** weeks, because the injuries sustained caused the **6%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$286.00 / week** for **11 6/7** weeks commencing December 22, 2010, through March 15, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to Gottlieb Memorial Hospital, $23,435.40 and Midwest Clinical Imaging, $2,476.00, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to Sections 8(a) and 8.2 of the Act.

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

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

Richard L. Simpson
Signature of Arbitrator

May 20, 2014
Date

MAY 21 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Laura Patino,	)	
	)	**15IWCC0658**
Petitioner,	)	
	)	
vs.	)	**No. 11 WC 02690**
	)	
Transilwrap Company Inc.,	)	
	)	
Respondent.	)	
	)	

FINDINGS OF FACTS AND CONCLUSIONS OF LAW

The parties agree that on December 16, 2010, the Petitioner and the Respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act and that their relationship was one of employee and employer. They agree that the Petitioner gave the Respondent notice of the accident which is the subject matter of this dispute within the time limits stated in the Act. They further agree that in the year preceding the injuries, the Petitioner earned $19,916.00, and that her average weekly wage was $383.00.

At issue in this hearing is as follows: (1) Did the Petitioner sustain accidental injuries that arose out of and in the course of her employment; (2) Is the Petitioner's current condition of ill-being causally connected to this injury or exposure; (3) Were the medical services provided to the Petitioner reasonable and necessary medical services and has the Respondent paid for all reasonable and necessary medical services; (4) Is the Petitioner entitled to TTD from December 22, 2010 through March 15, 2011; and (5) What is the nature and extent of the injury.

STATEMENT OF FACTS

The Petitioner testified that she began working for the Respondent on October 4, 2002. She stated that she was employed as a machine operator. The Respondent produces plastic. They manufacture plastic in different sizes and shapes, different thicknesses and different weights. She testified that the weight of the product depends upon the size of the pieces and the thickness of the fabrics. The Petitioner testified that when she began working for the Respondent she worked in the Bed Check department which primarily makes plastic for hospital use. Her normal work hours were from 6:00 a.m. to 2:30 p.m., "an eight hour day."

The Petitioner described her duties as a machine operator as being responsible for loading to rolls onto the machine, one on the top and one on the bottom. There are foam pieces that

connect the roll on the top and the roll on the bottom. The foam pieces are connected by a cable that is then put into the machine. The next person on the line then receives the plastic and cuts it into different sizes depending upon what the particular job they are doing requires.

The Petitioner was unable to give an accurate size for the rolls of plastic; however she demonstrated with her arms the circumference of the rolls. The parties agreed that she was describing essentially a two foot diameter for the rolls. She again stated that the pieces differed in their weight depending upon the dimensions and size the material was cut into.

The Petitioner testified that on December 16, 2010, she was working a 7:00 a.m. to 3:30 p.m. shift rather than her usual 6 to 2:30 shift. Also at that time her supervisor had assigned her to work as a machine operator in a different section of the facility. She was moved from the Bed Check department to the Fabrication department. She stated that in the Fabric department the machines are heavier and the materials/rolls are heavier as well. Because the material is heavier and the rolls are larger the machines use metal rods to hold the rolls in place. Petitioner testified that they had a very big order to fill. She was required to lift the rolls to put them on the rollers and they were very heavy, much heavier than what she lifted in Bed Check. Petitioner testified that when she moved the metal weight she felt a pain in her ovary. She noticed that every time she had to move the weight or the rollers she felt the pain. She does not know what time of the day this happened but it was in the beginning of the shift when she first started working with the heavier materials. The Petitioner testified that although the pain continued all day, she did finish working her shift and went home at the end of the day. She did not tell anyone at work about what happened.

When Petitioner went home, she took a pain pill and went to sleep. She did not think it was a big deal. The next day was the office Christmas party and they were only going to work four hours and then the party would be in the afternoon. She was still experiencing pain in her ovary so she did not go to work that day. The Petitioner testified that she did not work over the weekend, however while she was at home she noticed that every time she lifted anything heavy she felt the same pain in her ovary.

Petitioner returned to work on Monday she was still assigned to the Fabrication department. She worked the whole day in that department, each time she had to lift anything or move the rollers she felt more pain. The pain started the minute she started work and continued the whole day. She again worked the whole day, went home at the end of the day without telling anyone about the pain in her ovary.

On Tuesday when Petitioner placed the rollers up, she again felt pain around her ovary, only this time she felt a popping and pulling in the area around her ovary. By the end of the day she thought her ovary was going to explode. She continued to work her full shift but the pain increased as the day wore on. At 2:30 p.m. she closed the ticket on the machine and called her husband to pick her up and take her to the gynecologist. She testified that she still did not tell anyone at work what was happening because she thought it was her ovary and she did not want to tell anyone because of what it was.

At 3:30 p.m. her husband picked her up from work and took her to Dr. Pierce who examined me and told me the problem was not my ovary. He said it was "a hernia and it was

going to explode." Dr. Pierce sent me to Dr. Raul Villasuso at the Midwest Institute for Minimally Invasive Therapies.

On December 21, 2010, Petitioner saw Dr. Villasuso examined her and ordered a CT scan. He gave her a prescription for Tramadol and told her she could not work. This is the first time that the Petitioner told her supervisor what had happened. She told him because the doctor had told her she could not work.

On December 22, 2010, the Petitioner had the CT scan after which Dr. Villasuso confirmed the diagnosis of the hernia. The medical records indicate that Petitioner had a small inguinal hernia with clinically severe ilioinguinal neuritis. Because her pain was not relieved by conservative therapy she was scheduled for surgery on December 27, 2010. (PX 1)

After the surgery the Petitioner continued to have abdominal pain and to treat with Dr. Villasuso. Dr. Villasuso kept the Petitioner off of work after the surgery until March 16, 2011, when he allowed her to return to work on light duty with lifting restrictions including no lifting over ten pounds. (PX 1) Dr. Villasuso ordered scans of her liver and gall bladder in light of her continuing complaints, both of these were negative.

The Petitioner returned to Dr. Villasuso as directed on March 29, 2011, at which time she was still complaining of abdominal pain. The doctor continued her light duty, no lifting over 10 pounds for an additional 6 weeks. (PX1)

The Petitioner returned to see Dr. Villasuso on May 10, 2011. Although the Petitioner continued to complain of pain, and the doctor diagnosed her with residual ilioinguinal neuritis, he prescribed Naproxen for her pain and released her to return to work full duty with no restrictions. (PX1)

The Petitioner continued to see Dr. Villasuso through October 12, 2011. On that date Dr. Villasuso noted that she continued to complain of pain which was not relieved by conservative measures or surgery. He noted severe tenderness with pain at 10/10 preventing him from being able to examine the inguinal canal because of the pain. He recommended surgery to explore the inguinal canal for recurrent herniation and proceed to neurolysis of the offending nerve branches. (PX1) The Petitioner testified that she did not have the surgery.

On December 21, 2011, the Petitioner saw Dr. John J. Koehler, who is board certified in Occupational Medicine at the request of the Respondent pursuant to Section 12 of the Act. Dr. Koehler reviewed the medical records of Dr. Villasuso including the CT scan and the surgical reports as well as the pre-surgery and post surgery visits. According to Dr. Koehler the CT scan revealed a small umbilical hernia containing adipose tissue. There were no definite acute intra-abdominal abnormalities; there was a small amount of fluid in the right adnexal region. (RX1) Dr. Koehler further indicates in his report that the "CT scan clearly indicates there was no inguinal hernia, but there was a small umbilical hernia which, based upon my impression, would be an incidental finding unrelated to her right inguinal pain." (RX1)

Dr. Koehler noted that "Dr. Villasuso proceeded to operate on Ms. Patino with a pre-operative diagnosis of right inguinal hernia, a post-operative diagnosis of right inguinal hernia,

and the operation consisting of right inguinal hernia repair." After having reviewed all of the records, including the operative report, Dr. Koehler concluded that Petitioner underwent surgery that apparently was not indicated by any hernia being present. "It is possible that the surgeon, Dr. Villasuso, misread the CT which clearly states a small umbilical hernia, but no inguinal hernia. . . . During the operation there was "incarcerated fat present" according to his report. No hernia sac was identified." (RX1)

In Dr. Koehler's opinion the Petitioner did not suffer a work accident, "Please note: There was no "accident at work," she was simply undergoing her regular duties." He concludes that the question of MMI is irrelevant to work injury as in his opinion there was no work injury, however it is his opinion that Petitioner is not at MMI relative to the unnecessary surgery she underwent." (RX 1)

The Petitioner testified that she has not seen any other doctors regarding her abdominal pain since the visit to Dr. Koehler on December 21, 2011. She testified further that prior to the incident at work she had not experienced abdominal pain like the pain she experienced that day and after. She stated that currently she still has abdominal pain when she lifts or moves heavy objects.

According to the Petitioner she has experienced depression since her work injury. She is unable to do the things she used to do before the accident. It is difficult for her to do laundry; she has to make more trips with the laundry since she must carry it in smaller loads. The same is true of grocery shopping; she had difficulty carrying things like a gallon of milk. She stated that prior to the injury she liked to take long walks which she can no longer do because it causes pain. She also indicated that the injury has had an effect on her intimate relations with her husband, as it causes pain and is not the same.

Petitioner testified that she has returned to work full duty and is able to do her job, although it does tire her and cause her pain. She testified that currently she is back in her old department, Bed Check, however when she first returned to work she was kept in the Fabrication department and she believed she remained there for about two years before she was transferred back to Bed Check. She testified that she lives with pain. She also testified that when she has to lift something heavy she gets someone to assist her.

The Petitioner submitted medical bills in the amount of $26,032.81, for Gottlieb Memorial Hospital, consisting of $5,791.75 for 12/22/10, $16,830.31 from 12/27/10-12/28/10, $2,641.75 for liver scan on 2/28/11 and $769.00 for an Ultrasound of the Gallbladder on 2/3/11. (PX3) She also submitted bills from Midwest Clinical Imaging PC totaling $2,476.00 which included charges for an Office Consultation on 12/21/11 in the amount of $298.00, CT abdomen w/dye on 12/22/11 in the amount of $399.00, PRP I/Hern Init Reduc on 12/27/10 in the amount of $1,549.00, an Echo Exam of the Abdomen on 2/3/11 in the amount of $95.00 and Hepatobiliary Imaging on 2/28/11 in the amount of $135.00. (PX 4)

CONCLUSIONS OF LAW

It is the burden of every Petitioner before the Worker's Compensation Commission to establish with evidence every disputed issue litigated at trial, including the issues establishing Respondent's liability for benefits. *Board of Trustees of the University of Illinois v. Industrial Commission,* (1969), 44 Ill.2d 207 at 214, 254 N.E.2d 522, *Edward Don v Industrial Commission,* (2003) 344 Ill.App.3d 643, 801 N.E.2d 18.

The burden is upon the party seeking an award to prove by a preponderance of the credible evidence the elements of his claim. *Peoria County Nursing Home v. Industrial Comm'n*, 115 Ill.2d 524, 505 N.E.2d 1026 (1987). This includes the nature and extent of the petitioner's injury.

The burden is on the party seeking the award to prove by a preponderance of credible evidence the elements of the claim, particularly the prerequisites that the injury complained of arose out of and in the course of the employment. *Hannibal, Inc. v. Industrial Commission,* 38 Ill.2d 473, 231 N.E.2d 409, 410 (1967)

The burden of proving disablement and the right to temporary total disability benefits lies with the Petitioner who must show this entitlement by a preponderance of the evidence. *J.M. Jones Co. v. Industrial Commission,*71 Ill.2d 368, 375 N.E.2d 1306 (1978)

To be compensable under the Act, the injury complained of must be one "arising out of and in the course of the employment". *820 ILCS 305/2*(West 1998).

An injury "arises out of" one's employment if it originates from a risk connected with, or incidental to, the employment, involving a causal connection between the employment and the accidental injury. *Parro v. Industrial Comm'n,* (1995) 167 Ill. 2d 385,393, 212 Ill. Dec. 537, 657 N.E. 2d 882.

An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

While it is true than an employee's uncorroborated testimony will not bar a recovery under the Act, it does not mean that the employee's testimony will always support an award of benefits when considering all the testimony and circumstances shown by the totality of the evidence. *Caterpillar Tractor Co. v. Industrial Commission,* 83 Ill. 2d. 213, 46 Ill. Dec. 687, 414 N.E. 2d 740 (1980).

Did the Petitioner sustain accidental injuries that arose out of and in the course of her employment?

Petitioner credibly testified that she was working for the Respondent on December 16, 2010, when she was reassigned from her regular department to the Fabrication department. She testified that the materials they worked with in this department were heavier than the materials

she worked with on a daily basis and that the machines were heavier as well. She testified that when she put the first roll of material on the roller and pulled the metal arm which also weighed more than the foam ones she was used to working with she felt pain in the area of her ovary. She stated that the pain continued each time she lifted or moved something heavy. She stated that she continued to work in this assignment over the next five or six days and that each time she worked she felt increased pain, culminating with the pain she experienced on Tuesday which included popping and pulling sufficient to make her think her ovary was going to explode. It was at the end of her shift that day that she decided to seek medical treatment, still believing that the problem was with her ovary. As soon as she saw the doctor and learned that she had a hernia and that she would need to be off of work she notified the Respondent of the situation.

The Petitioner can point to a specific date and time and an activity when she began to feel the pain. She was working in a different department, with heavier materials and heavier machines than normal and when she began to ready the machine for the first time, lifting the heavy roll and then moving the heavy metal rod for the machine that she first felt the pain. Clearly the incident is work related and in the scope of her employment.

The Respondent's Section 12 examiner, Dr. Koehler opined that the Petitioner did not suffer a work related injury, he does not give the factors upon which he based that opinion other than that the Petitioner was performing her regular work duties at the time of the injury.

The Petitioner has met her burden with respect to the

Is the Petitioner's current condition of ill-being causally connected to this injury or exposure?

The Arbitrator finds that a causal relationship does exist between Petitioner's injury at work and her current condition of ill-being, namely a repaired inguinal hernia with recommendation for revision surgery. Petitioner had no history of inguinal or abdominal pain prior to December 16, 2010. On that date, while performing her work duties, Petitioner began to suffer such symptoms. Although the Petitioner at first believed the pain and injury was to her ovary, subsequent medical examinations revealed she had a hernia rather than an injury to her ovaries as she believed. The pain she described did not vary or change when she went from the gynecologist to Dr. Villasuso, who diagnosed the hernia. The Arbitrator does not find the opinion of Dr. Koehler to be persuasive on the issue. An injury is accidental within the meaning of the Worker's Compensation Act when it is traceable to a definite time, place and cause and occurs in the course of the employment unexpectedly and without affirmative act or design of the employee. *Matthiessen & Hegeler Zinc Co. v Industrial Board,* 284 Ill. 378, 120 N.E. 2d 249, 251 (1918)

Dr. Koehler states that "she developed right inguinal and pelvic pain while at work." However, he states that she did not have a work injury, therefore her current condition is unrelated. This observation and opinion is not consistent with the evidence that was presented or documented in Petitioner's medical records.

A medical opinion is not necessary to establish causation. *See Price v. Industrial Comm'n*, 278 Ill. App. 3d 848, 853-54 (1996).

In the present case, Petitioner credibly testified that she was asymptomatic prior to her work accident of December 16, 2010, and that she was subsequently symptomatic. The Arbitrator finds this chain of events to be persuasive, and agrees that the Petitioner's current condition of ill-being is related to her work accident.

Were the medical services provided to the Petitioner reasonable and necessary medical services and has the Respondent paid for all reasonable and necessary medical services?

The Petitioner sustained accidental injuries on December 16, 2010, that arose out of and in the course of her employment. Her current condition of ill-being is causally connected to the injuries she suffered that day. Based upon these findings and the medical records provided by the treating physician, the Arbitrator finds that the medical treatment provided to Petitioner was reasonable and necessary, and that Respondent is liable for all unpaid medical bills related to the injury the Petitioner sustained at work on December 16, 2010. The Arbitrator bases her decision on the credible testimony of the Petitioner.

The Petitioner underwent surgical intervention per the recommendation of Dr. Villasuso on December 27, 2010. After this, further diagnostic procedures were performed due to her continued symptomology. Dr. Villasuso diagnosed a right inguinal hernia, and recommended a surgical repair. In his operative report, he notes visualizing an "incarcerated piece of fat [sic] of preperitoneal fat." (PX 2) This was repaired, and Dr. Villasuso notes that "I was satisfied with the treatment of the herniated sac which was fully retracted into the internal inguinal ring." (Id.)

Dr. Koehler was not in the operating room at the time of the repair. He bases his opinion on the CT scan of December 22, 2010, which does not note an inguinal hernia. (RX 1) Dr. Villasuso had the opportunity to personally visualize the herniated sac, which was fully retracted into the inguinal ring by the conclusion of his surgical repair. The Arbitrator relies on the operative report of Dr. Villasuso, noting his findings.

Therefore, the Arbitrator awards the past medical treatment submitted by the Petitioner at trial, subject to the medical fee schedule. These bills include Gottlieb Memorial Hospital, $23,435.40, and; Midwest Clinical Imaging, $2,476.00. The Arbitrator notes that the May 2, 2009 scan billed by Midwest Clinical Imaging is unrelated to this case, was not claimed by the Petitioner, and is not awarded.

Is the Petitioner entitled to TTD from December 22, 2010 through March 15, 2011?

Having determined that the Petitioner's current condition of ill being is causally connected to her accident at work, the Arbitrator finds that the Petitioner is entitled to receive temporary total disability benefits for the period December 21, 2010 through March 15, 2011. Petitioner testified that she was off work until March 16, 2011 per Dr. Villasuso, and his records confirm this. The Petitioner testified that her work status notes were taken to Respondent by her husband. There is no evidence in the record to refute this testimony. Therefore, the Arbitrator

awards TTD benefits from December 21, 2010 through March 15, 2011 at a rate of $286.00 per week.

What is the nature and extent of the injury?

Having found that the Petitioner did suffer an accident that arose out of and in the course of her employment and that her current condition of ill-being is causally connected to that injury, the next issue is the nature and extent of the injury suffered by the Petitioner. Petitioner testified that she has returned to her regular work with Respondent, although she suffers continued symptomology. She testified at trial that she continued working in the fabrication department for some years before returning to her original department. Petitioner testified that she has difficulty with her work at Transilwrap due to ongoing abdominal pain. She also has issues at home – she has difficulty doing the laundry, needing to work with smaller loads and making more work and has difficulty carrying groceries at the store and up to her apartment. She has gained weight. Sexual relations with her husband have become difficult.

The Arbitrator also finds it persuasive that a revision surgery was recommended in October 2011, although not performed. Based upon the foregoing discussion, the Arbitrator finds that Petitioner suffered 6% loss of use of a person as a whole as a result of the injury. Given the nature of the injury the Petitioner suffered following the December 16, 2010, incident, she is entitled to have and receive from the Respondent compensation for 6% loss of use of the person as a whole, or 30 weeks at a weekly PPD rate of $286.00 / per week.

ORDER OF THE ARBITRATOR

Petitioner is found to have suffered a permanent injury pursuant to Section 8(d)2 of the Act. For the foregoing reasons, Respondent shall pay Petitioner permanent partial disability benefits of **$286.00/week** for **30** weeks, because the injuries sustained caused the **6%** loss of use of man as a whole, as provided in Section 8(d)2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$286.00 / week** for **11 6/7** weeks commencing December 22, 2010, through March 15, 2011, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical expenses with respect to Gottlieb Memorial Hospital, $23,435.40 and Midwest Clinical Imaging, $2,476.00, pursuant to the medical fee schedule or by prior agreement, whichever is less, pursuant to Sections 8(a) and 8.2 of the Act.

Deborah L. Simpson
Signature of Arbitrator

May 20, 2014
Date

STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Dianna L Taylor,
Petitioner,
vs.

15IWCC0659
NO: 12 WC 24840

Wal-Mart Associates, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2014 is hereby affirmed and adopted.

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

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

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

DATED: AUG 24 2015
KWL/vf
O-8/10/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0659

Case# 12WC024840

TAYLOR, DIANNA L
Employee/Petitioner

WAL-MART ASSOCIATES INC
Employer/Respondent

On 11/10/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4084 THE LAW OFFICE OF TIMOTHY J DEFFET
PO BOX 180335
CHICAGO, IL 60618

0560 WIEDNER & McAULIFFE LTD
BRIAN J KOCH
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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

15IWCC0659

Dianna L. Taylor
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # **12 WC 24840**

Consolidated cases:

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Gerald Granada**, Arbitrator of the Commission, in the city of **New Lenox**, on **9/24/14**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0659

FINDINGS

On **7/6/12**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did 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 **$12,808.19**; the average weekly wage was **$246.31**.

On the date of accident, Petitioner was **47** years of age, ***married*** with **0** 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** 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

Petitioner failed to meet her burden of proof on the issue of accident. Therefore, all benefits are denied.

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

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

Signature of Arbitrator

11/5/14
Date

NOV 10 2014

FINDINGS OF FACT

This is a claim for benefits in which the Petitioner alleges injuries to her arms as a result of repetitive trauma from her job as a floor associate with the Respondent. The alleged accident date is July 6, 2012 and the issues in dispute are: 1) accident, 2) notice, 3) causation, 4) medical expenses, 5) TTD, 6) penalties and attorney fees, and 7) nature and extent.

Petitioner began working for the Respondent in 2009 as a part time floor / sales associate. She testified that her job duties included the following activities: going to the warehouse and loading boxes weighing 10-40 pounds onto a cart; bringing clothes out to the sales floor on rolling racks; scanning the clothes with a scanner gun 4-5 times per day; folding clothes; cleaning up various areas; picking up clothes and bringing them to the correct department; stocking groceries in the freezer and in the grocery area; and placing loose clothes in storage bins that required Petitioner to use a ladder. Petitioner testified in her cross examination that each day of work, she did a variety of jobs in different departments and was not sure what her duties would be the next day.

Petitioner testified that on July 6, 2012, her left shoulder hurt and her right shoulder was aching. Petitioner testified that she notified her supervisor, Theresa Guy on that day that she hurt her shoulder. Petitioner was taken to Manager Jeff Farrin's office in the back of the store and eventually was told to go home that day.

Petitioner's medical records begin with a July 3, 2012 visit to Adventist Health Partners/Corwin Medical Care in Plainfield, Illinois where she was examined by Darlene Peters, a certified nurse practitioner. She described a two month onset of shoulder pain in the left shoulder with radiation to the left arm, which she had associated symptoms of muscle spasm. In an additional information aspect, Petitioner indicated her pain started shortly after getting a massage. There is no indication as to where she received this massage. Petitioner could not recall when she had the massage or where she had this massage. On redirect testimony, Petitioner remembered clearly telling the massage therapist not to touch her left shoulder. On her July 3, 2012 visit with nurse Peters, Petitioner advised that she did work at Wal Mart and regularly does lifting for her job. The history indicated that her initial pain started prior to the massage but has become progressively worse over time and that her pain was not at its highest as she just drove back from Florida. In addition to her shoulder pain, Petitioner described chronic problems including hyperglycemia, gout, dry eyes, hypercholesterolemia, CAD, native vessel, transient cerebral ischemia, alcohol abuse, unspecified Vitamin D deficiency, HTN benign, hyperthyroidism, occlusion and stenosis of carotid artery, tobacco use and elevated liver enzymes. Petitioner as recently as 2011 underwent ablative therapy. Petitioner was on a host of medications including Synthroid, Levolo, Lexapro, Trilipix, Colcrys, Amlodipine, Vesylate, Vitamin D, Ibuprofen, Metoprolol Tartrate, Lisinopril and Probenecid. Petitioner was provisionally diagnosed with left shoulder pain and referred for a visit to Dr. Kao.

On July 6, 2012, Dr. Kao examined Petitioner at Corwin Medical Center. Petitioner described a two to three month duration of left shoulder pain with no aggravating factors. Dr. Kao diagnosed Petitioner with rotator cuff capsule sprain and strain with left supraspinatus and external rotators. Dr. Kao provided an injection into the left shoulder subacromial space on that same visit. Petitioner then saw Dr. Kao on July 11, 2012, at which time Dr. Kao prepared FMLA forms at Petitioner's request. In the FMLA form, the word "personal" is written, replacing the FMLA designation. Petitioner admitted on cross examination that this was her handwriting and that she wrote the word personal on the form. Dr. Kao indicated on the form that Petitioner had a condition commencing three months ago with a probable duration of condition being four to six weeks. Dr. Kao indicated that he treated Petitioner on July 3, 2012 and recommended physical therapy two to three times per week for four to six weeks. Dr. Kao indicated that Petitioner was unable to perform job functions due to the condition which were in relation to a diagnosis of left shoulder rotator cuff tendonitis and tendinosis for the left shoulder arm and cervical pain. As of July 11, Dr. Kao indicated that an MRI could be required. As of July 6, 2012,

petitioner was excused from work for two days. Dr. Kao indicated petitioner could return to work restricted duty on July 10, 2012 to include no pulling or lifting with her left arm. As of July 11, 2012, however Dr. Kao indicated petitioner was on FMLA.

On July 10, 2012, petitioner reported to Adventist Hospital Rehabilitation. In the records from that date, Petitioner made no reference to a work event.

On July 18, 2012 Petitioner returned to Dr. Kao's care with continued pain in her left shoulder referred to as severe. Petitioner also described some mild symptoms in the right shoulder per physical therapy. Dr. Kao diagnosed Petitioner with a rotator capsule sprain, bilateral with a suspicion of a left shoulder tear. Dr. Kao recommended an MRI of the left upper extremity. The MRI was performed on July 23, 2012 which was consistent with osteoarthritis of the acromioclavicular joint with bone marrow edema about the joint likely related to contusion with a supraspinatus and infraspinatus tendinosis with mild atrophy of the muscles with no evidence for rotator cuff tear. Petitioner was found to have tenosynovitis of the biceps tendon and SLAP lesion at the twelve to three o'clock position. Petitioner underwent the MRI at Adventist Bolingbrook Hospital. Dr. Kao referred Petitioner to Dr. Lee.

On August 30, 2012, Dr. Lee continued Petitioner off of work through September 13, 2012. Petitioner continued to complain of left shoulder pain. She indicated the pain was aggravated by lifting and movement with associated symptoms including clicking or popping, difficulty going to sleep, night pain, nighttime awakening, tenderness and weakness. Dr. Lee indicated Petitioner's July 30, 2012 injection helped for two weeks and that Petitioner has been unable to return to work secondary to pain and overhead lifting. Following his exam Dr. Lee felt petitioner's work has aggravated her preexisting condition and continued to authorize her off of work.

On October 30, 2012, Dr. Lee performed a left shoulder slap tear repair, debridement of the rotator cuff, acromioplasty and acromioclavicular joint resection. On November 1, 2012, Petitioner was examined at ATI Physical Therapy status post left shoulder SLAP repair and distal clavicle resection. She initiated physical therapy at ATI Physical Therapy for range of motion. On November 1, 2012, Dr. Lee authorized petitioner off of work until further notice with a follow up scheduled for November 15, 2012.

On November 14, 2012, Petitioner was examined by Dr. Lieber at the Respondent's request pursuant to Section 12 of the Act. Dr. Leiber opined that Petitioner's complaints were not related to the activities of July 6, 2012 during her employment but that of preexistent abnormalities within the right shoulder area and secondary to the October 30, 2012 surgical intervention. Dr. Lieber further opined that Petitioner's preexisting condition was not aggravated by her work activity. Dr. Lieber opined that the need for the surgical intervention in the left shoulder was related to preexisting abnormalities of the left shoulder area and not that of the alleged accident of July 6, 2012.

Petitioner remained under the care of Dr. Lee following her left shoulder surgery. Dr. Lee authorized Petitioner off of work following surgery through April 2013. On April 15, 2013 following her ATI Physical Therapy regimen and surgery, Petitioner underwent an FCE at ATI. Following her FCE, Dr. Lee opined that Petitioner had a permanent restriction of lifting up to waist level at forty pounds with an occasional lift up to eight pounds above shoulder. Petitioner presented this restriction to her store on April 30, 2013 and she returned to work for respondent, who provided Petitioner work within her restrictions. Petitioner resigned her employment with Respondent as of June 21, 2013 to care for her son. Petitioner testified to having continued trouble with her left

shoulder in that she could not carry laundry baskets, could not participate in basketball or volleyball activities. Petitioner testified that as long as she stays within her boundaries, she is ok.

Lisa Ramocki was called to testify on behalf of the Respondent. Ms. Ramocki is the personnel manager for the Shorewood Wal-Mart store location where petitioner worked testified on behalf of Respondent. Ms. Ramocki testified that she was in the personnel department in July 2012 when Ms. Taylor alleged a date of accident. Ms. Ramocki testified that she had no knowledge of an individual by the name of Theresa Guy, who Petitioner testified she provided notice to on the alleged date of accident. Ms. Ramocki testified that the Shorewood store employed approximately 400 employees and 40 supervisors at any given time. Ms. Ramocki was unaware of any supervisor by the name of Theresa Guy.

Ms. Ramocki testified that she was familiar with Petitioner as she testified that Petitioner had some health issues and submitted LOA (Leave of Absence) paperwork to Ramocki's attention on several occasions. Respondent's exhibits document Petitioner's leave of absence paperwork filed for Petitioner's heart condition and gout condition in August and November 2011.

Ms. Ramocki testified that she and Petitioner discussed her situation on July 23, 2012. At that time, Ms. Ramocki asked Petitioner if she had an accident at Wal-Mart. Petitioner advised Ms. Ramocki that she did not have an accident at Wal-Mart. Furthermore, Ms. Ramocki testified that Petitioner did not identify anyone to whom Petitioner orally reported an accident. Ms. Ramocki testified that she asked if Petitioner wanted to file an accident report and Petitioner informed Ms. Ramocki that Petitioner has a lawyer and that she would not fill out any LOA paperwork because of her lawyer's instructions. Petitioner then submitted LOA paperwork to Ms. Ramocki on July 24, 2012.

Ms. Ramocki testified that Petitioner was very consistent with submission of LOA paperwork to the store as required by all employees out on leave. Ms. Ramocki testified that the first time she heard that Ms. Taylor had a work accident was her receipt of paperwork from the Workers Compensation Commission. Ms. Ramocki testified that Petitioner returned to Wal-Mart answering phones and working in the fitting rooms, before Petitioner ultimately resigned her employment.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has failed to meet her burden of proof. In support of this finding, the Arbitrator notes various factors in Petitioner's testimony and medical evidence that clearly cast doubt on her credibility, but also fail to show a repetitive trauma accident. Petitioner's testimony was essentially, that on July 6, 2012, her left shoulder hurt and her right shoulder ached. Although she described her various work activities, these activities were not sufficiently repetitive or tediously repeating. Her employment tasks were quite varied according to her own description. She testified that on any given day, she was unsure what she was going to be assigned to do. Petitioner described some of her work activities, such as picking up clothes, stocking the grocery section, loading boxes on carts, rolling racks of clothing, etc. - but there was simply no evidence presented indicating whether these activities were performed by Petitioner repetitively over an extended period of time. There was no indication on the duration of these various activities, the amount of force required to perform each activity, the number of times each activity was performed, or any other factor that would indicate any of these activities were repetitive in nature. Furthermore, there was no evidence the Petitioner had any physical complaints contemporaneously with or following any of the various job activities she described.

15IWCC0659

Ms. Ramocki's testimony casts further doubt on the credibility of Petitioner's claim that Petitioner actually reported any accident. Ms. Ramocki's unrebutted testimony established that the Petitioner was familiar with Ms. Ramocki since Petitioner had submitted leave of absence forms to Ms. Ramocki in the past for other unrelated medical conditions. However, when Ms. Ramocki asked Petitioner on July 23, 2012, if Petitioner had an accident, Petitioner responded that she did not have an accident.

Petitioner's own medical records also show that Petitioner's complaints to her left arm clearly pre-existed her alleged accident date and there is no mention of her work activities aggravating these conditions when she saw either Nurse Peters or Dr. Kao. There was no mention of her work activities aggravating her conditions until she saw Dr. Lee in August, 2012 – which by that time Petitioner was telling Respondent's personnel coordinator, Lisa Ramocki, to contact Petitioner's legal counsel.

In reviewing all these facts, the Arbitrator concludes that the evidence does not support Petitioner's claim that she had a repetitive trauma accident on July 6, 2012.

2. Based on the Arbitrator's findings with respect to the issue of accident, all other issues are rendered moot and Petitioner's claim for benefits is denied.

STATE OF ILLINOIS	)	☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
	) SS.	☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
COUNTY OF COOK	)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
			☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

James Booker,

Petitioner,

15IWCC0660

vs.

NO: 12 WC 23126

Korellis Roofing Inc.,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 11, 2014 is hereby affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,600.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 24 2015
KWL/vf
O-8/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

15IWCC0660

BOOKER, JAMES
Employee/Petitioner

Case# **12WC023126**

KORELLIS ROOFING INC
Employer/Respondent

On 9/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1315 DWORKIN AND MACIARIELLO
DAVID VanOVERLOOP
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

0075 POWER & CRONIN LTD
JEFF REDICK
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)
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)

15IWCC0660

James Booker
Employee/Petitioner
v.

Korellis Roofing, Inc.
Employer/Respondent

Case # 12 WC 23126

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 Lynette Thompson-Smith, Arbitrator of the Commission, in the city of Chicago, on July 28, 2014. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

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

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

On this date, the 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, the Petitioner earned $82,524.52; the average weekly wage was $1,587.01.

On the date of accident, Petitioner was 42 years of age, ***married*** with 2 dependent children.

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

Respondent shall be given a credit of $69,979.14 for TTD, $4,417.70 for TPD, $0 for maintenance, and $0 for other benefits, for a total credit of $74,396.84.

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

ORDER

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of $1,058.01/week for 66-1/7 weeks, as provided in Section 8(b) of the Act.

Prospective Medical Treatment

Respondent shall authorize and pay for the surgery as prescribed by Dr. Kelikian, as well as any reasonable and necessary post-surgical care, pursuant to Section 8(a) of the Act.

Respondent shall be given a credit of $69,979.14 for temporary total disability benefits that have been paid pursuant to Section 8(b) of the Act and $4,417.70 for temporary partial disability paid to Petitioner pursuant to 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.

FINDINGS OF FACT

The disputed issues in this matter are 1) causal connection; 2) temporary total disability; and 3) whether the petitioner is entitled to prospective medical treatment.

Jim Booker, ("Petitioner") was involved in an undisputed accident while working for Korellis Roofing, ("Respondent") on March 30, 2011. On that date, Petitioner was performing his normal job functions as a roofer when he fell approximately 40 feet through a roof, sustaining injuries to his face and right ankle.

Petitioner was taken by ambulance to Advocate Christ Medical Center, where he underwent: 1) an emergency open reduction, 2) an internal fixation for a maxillary fracture with bone graft; 3) a closed reduction of a nasoseptal fracture, 4) an emergency open reduction internal fixation for a right, comminuted, medial malleolus fracture in his right ankle, with repair of the right deltoid ligament. PX1 & 2.

The Arbitrator notes that Petitioner underwent multiple subsequent procedures for his facial injury and continues to receive treatment for that aspect of his injury, but the record reflects the issues of the subject hearing are limited in scope to treatment of the right ankle. PX2, 3 & 6.

Petitioner underwent post-surgical care for his right ankle with Dr. Kevin Luke of Parkview Orthopedic Group. Petitioner continued to experience difficulties with his right ankle and following a CT scan performed on April 23, 2012, he was referred to Dr. Paul DeFrino of Parkview Orthopaedic Group, to undergo a second surgery. On June 1, 2012, Dr. DeFrino performed an arthroscopy with debridement and drilling of a lateral, talar, osteochondritis dissecans lesion, with removal of painful hardware and an open excision of a bony osteophyte, on the right distal tibia. PX1.

Petitioner continued to follow-up with Dr. DeFrino, complaining of pain and difficulty walking and standing. On September 10, 2012, Dr. DeFrino noted that Petitioner continued to complain of pain and discomfort, but released Petitioner from care with the permanent restriction of no extended length of time on high-pitched roofs. PX1.

Petitioner testified that after his release from Dr. DeFrino, he experienced a gradual increase of pain in his ankle while working and sought a second opinion from Dr. Armen Kelikian of NorthShore Orthopaedics, on January 28, 2013. Dr. Kelikian recommended an MRI of Petitioner's right ankle to check for cartilaginous lesions. The MRI was performed on February 11, 2013 and was read to show an osteochondral lesion on the lateral dome of Petitioner's talus; and a peroneal tendon tear. Based on these findings, Dr. Kelikian performed an arthroscopy with de novo cartilage transplant, gastroc resection and peroneus brevis tendon repair, on May 9, 2013. PX4- 5.

Petitioner returned to work with light duty restrictions, on October 7, 2013. However, he continued to experience pain and discomfort in his right ankle. A new MRI was performed on November 15, 2013, leading Dr. Kelikian to prescribe a fourth surgery for

Petitioner's right ankle under the suspicion that Petitioner suffered from another tendon tear. PX5.

On December 20, 2013, Petitioner underwent an independent medical examination ("IME") by Dr. Anand Vora at Respondent's request. Dr. Vora recommended Petitioner undergo an ultrasound of his right ankle, to determine if there was a tendon tear, prior to having a surgical procedure. The ultrasound was performed on February 7, 2014 and was read to show no tendon tear, but revealed subluxation of the peroneus brevis tendon. Based on these findings, Dr. Kelikian recommended a retinacular repair and groove deepening. PX5.

Deposition of Dr. Armen S. Kelikian dated May 12, 2014

Dr. Kelikian testified that he has been practicing medicine for thirty-three (33) years, a good part of which was at Northwestern; and that he is a clinical professor of orthopaedic surgery at Northwestern. He focuses his practice on foot and ankle treatment approximately ninety-nine percent (99%) of the time and performs about five hundred (500) ankle surgeries a year. PX8.

Dr. Kelikian testified that following the peroneal tendon repair, gastroc resection and cartilage transplant on May 9, 2013, Petitioner continued having pain in his ankle, five months after the surgery. He further testified that the November 15, 2013 MRI was performed because he suspected a tendon tear; and he recommended a revision surgery. However, prior to surgery, Dr. Kelikian received the suggestion from Dr. Vora that an ultrasound be performed on Petitioner's right ankle, which did not show a new tendon tear, but did show the tendon subluxating or the tendon popping out of the socket. PX8.

Dr. Kelikian testified that the findings on the ultrasound correlated with Petitioner's subjective symptomatology and physical examination, and that Petitioner would need a retinacular repair to tighten the retinaculum and prevent the subluxation of the tendon. Furthermore, Dr. Kelikian explained that Petitioner's work on roofs with inclines and declines, front-to-back angles and side-to-side angles, would provoke the subluxation, causing the tendon to pop out of its groove within the ankle, exacerbating his condition. Dr. Kelikian testified that all activity including walking, standing, or squatting on a roof pitched more than seven (7) to eight (8) degrees would exacerbate Petitioner's condition. Dr. Kelikian testified affirmatively that the procedure he was recommending was reasonable and necessary to treat Petitioner's ongoing ankle injury and symptoms and directly related the current condition of Petitioner's right ankle to the work injury of March 30, 2011. PX8.

Respondent entered into evidence video surveillance of Petitioner, on four separate occasions, between December 8, 2013 and February 5, 2014. Of note, the surveillance of February 1, 2014 and February 5, 2014, show Petitioner operating a snow blower to remove snow from his driveway. Surveillance is significant for showing that on February 1, 2014 and February 5, 2014 the petitioner was actively engaged in snow removal of his driveway in which he was pushing a snow blower forcefully and seen

dragging the snow blower machine through the uneven accumulated snow on the driveway surface. It is noted that the petitioner appears to be moving throughout the video, while performing snow removal activities without apparent distress or difficulty and that the Petitioner was able to stand using a broom to remove snow from a vehicle parked in his driveway. Again, all movements were noted to be without distress or difficulty. RX2.

Petitioner testified that on those occasions it was necessary to clear his driveway so that his wife could go to work. He further testified, and the video shows, that his driveway is relatively flat and that the conditions are not similar to the conditions of working on a pitched roof covered in roofing materials and debris. Petitioner identified the snow blower being used as self-propelled, so he would only need to walk behind it.

After reviewing the video, Dr. Kelikian testified that the evidence did not change his opinion and he continued to recommend that the petitioner undergo a surgical retinacular repair and groove deepening procedure, though he admitted that the procedure might not produce any benefit to the petitioner in the form of increased function or decreased pain. Dr. Kelikian testified that he had reviewed the surveillance video and that it also did not change his opinions regarding Petitioner's ankle condition, the necessity of work restrictions or the need for surgery. Similar to Petitioner's testimony, Dr. Kelikian found the activity of using a snow blower not comparable to performing work on a pitched roof, the latter of which he maintained as the exacerbating factor in Petitioner's current condition. PX8.

Deposition of Dr. Anand M. Vora dated June 4, 2014

Dr. Vora testified that as part of his education and training, he had participated in an orthopaedic surgery residency at Northwestern; during which time Dr. Kelikian was also on faculty and that he had been one of his teachers. Dr. Vora testified that he was hired by the Respondent to provide his opinions, and that 75% of the examinations he performs in this capacity are done on behalf of Respondents. Dr. Vora agreed with the findings of subluxation identified on the ultrasound, but testified that he believed surgery wasn't necessary and instead found Petitioner to be at MMI, and that the previous restrictions of "no work on steep pitched roofs" was appropriate. Dr. Vora testified that the type of subluxation found on Petitioner' s ultrasound could be argued to be a normal variant and not a pathological finding and therefore, he would not operate on such a subluxation. He further testified that the petitioner had no pathology of the subtalar joint; that his pathology was in the ankle. He admitted that subluxation, as was identified on the ultrasound, can cause pain and irritation, and that such subluxation can be exacerbated by activity or positioning on a sloped incline such as a roof. Dr. Vora acknowledged that a retinacular repair to surgically correct subluxation is within the standard of care and other surgeons may perform such a procedure, but that he does not perform that type of surgery in his practice. RX1.

Dr. Vora also reviewed that the surveillance footage and testified that he believed it showed Petitioner using snow removal machinery and walking on icy surfaces with no

apparent distress and apparent normal function. He further testified that the surveillance footage supported his opinion that the petitioner was at MMI. Upon cross-examination, Dr. Vora admitted that the driveway shown in the video was relatively flat and not inclined, as one would expect a roof to be. RX1.

Petitioner testified that he continues to experience pain and discomfort in his right ankle with popping and clicking, particularly while at work. He described increased pain throughout the day worsened by working on inclined roofs; walking and carrying materials across the uneven surfaces created by the roofing materials and debris. Petitioner testified that despite Dr. Kelikian's recommendations, that he refrain from working in such an environment, he was forced to return to work following Dr. Vora's March 2, 2014 report, in order to support his family. Further, the constant pain has prevented Petitioner from engaging in activities he used to enjoy prior to his injury, such as playing with his children and riding his motorcycle. Petitioner testified that he would undergo the treatment recommended by Dr. Kelikian if it was to be awarded.

CONCLUSIONS OF LAW

F. In support of the Arbitrator's decision regarding whether the Petitioner's current condition of ill-being regarding his right ankle is causally related to the March 30, 2011 work injury, the Arbitrator concludes the following:

It is within the province of the Commission to determine the factual issues, to decide the weight to be given to the evidence and the reasonable inferences to be drawn there from; and to assess the credibility of witnesses. *See, Marathon Oil Co. v. Industrial Comm'n*, 203 Ill. App. 3d 809, 815-16 (1990). And it is the province of the Commission to decide questions of fact and causation; to judge the credibility of witnesses and to resolve conflicting medical evidence. *See, Steve Foley Cadillac v. Industrial Comm'n,* 283 Ill. App. 3d 607, 610 (1998).

It is established law that at hearing, it is the employee's burden to establish the elements of his claim by a preponderance of credible evidence. *See, Illinois Bell Tel. Co. v. Industrial Comm'n.*, 265 Ill. App. 3d 681; 638 N.E. 2d 307 (1st Dist. 1994). This includes the issue of whether Petitioner's current state of ill-being is causally related to the alleged work accident. *Id.* A claimant must prove causal connection by evidence from which inferences can be fairly and reasonably drawn. *See, Caterpillar Tractor Co. v. Industrial Comm'n.*, 83 Ill. 2d 213; 414 N.E. 2d 740 (1980). Also, causal connection can be inferred. Proof of an employee's state of good health prior to the time of injury and the change immediately following the injury is competent as tending to establish that the impaired condition was due to the injury. *See, Westinghouse Electric Co. v. Industrial Comm'n*, 64 Ill. 2d 244, 356 N.E.2d 28 (1976). Furthermore, a causal connection between work duties and a condition may be established by a chain of events including Petitioner's ability to perform the duties before the date of the accident and inability to perform the same duties following that date. *See, Darling v. Industrial Comm'n*, 176 Ill.App.3d 186, 193 (1986).

Petitioner presented with consistent complaints of pain and discomfort throughout his treatment with Drs. Park, DeFrino and Kelikian in the months and years following the undisputed work accident. Furthermore, Dr. Kelikian testified that Petitioner's current right ankle condition is directly related to the work accident of March 30, 2011. Moreover, although Dr. Vora disagrees with Dr. Kelikian, regarding the need for surgical intervention, he did not opine that Petitioner's ongoing right ankle complaints are unrelated to the work accident of March 30, 2011. Dr. Vora did opine that the restriction of "no work on steep-pitched roofs" was appropriate. As such, the Arbitrator finds the current condition of Petitioner's right ankle to be causally related to the March 30, 2011 work accident.

K. In support of the Arbitrator's decision regarding whether the Petitioner is entitled to any prospective medical care, the Arbitrator concludes the following:

The Arbitrator finds Dr. Kelikian to be more persuasive in his testimony and places more weight on his opinions than those of Dr. Vora. In doing so, the Arbitrator notes Dr. Kelikian's background and career of 33 years performing up to 500 ankle surgeries per year, including extensive time on staff with Northwestern as an orthopedic surgeon and faculty member. Dr. Vora testified that Dr. Kelikian had been one of his professors while he performed his residency at Northwestern and studied foot and ankle surgery. Also, Dr. Vora testified to being hired by the Respondent in this matter to provide his opinions, and that 75% of the examinations he performs in this capacity are done on behalf of Respondents.

Drs. Kelikian and Vora agree that the ultrasound performed demonstrates subluxation of Petitioner's tendon. Furthermore, the doctors agree that this condition can cause pain and irritation, and is exacerbated by work on inclines such as roofs. Dr. Kelikian testified affirmatively that a retinacular repair is indicated based on Petitioner's subjective complaints, objective physical examination, and diagnostic testing. Dr. Kelikian opined that this is the necessary treatment to address Petitioner's condition and may relieve Petitioner's ongoing complaints. Dr. Vora testified that while such a procedure is performed in the surgical community, he does not perform the surgery in his practice and does not recommend it for Petitioner.

As discussed above, the Arbitrator finds Dr. Kelikian to be more persasive and places more weight on his opinions and recommendations than those of Dr. Vora. As such, the Arbitrator finds Petitioner to be entitled to the prospective medical care as recommended by Dr. Kelikian. Respondent is ordered to pay all the reasonable, necessary and related charges for such surgery and any reasonable and necessary rehabilitative treatment needed, pursuant to Section 8(a) of the Act.

L. In support of the Arbitrator's decision regarding whether Petitioner is entitled to temporary total disability benefits, the Arbitrator concludes the following:

The record reflects Petitioner is claiming entitlement to 67-5/7 weeks of temporary total disability benefits ("TTD"), and that Respondent has paid 66-1/7 weeks, the difference being eleven individual days on which Petitioner attended appointments with his treating physicians or underwent diagnostic testing for his work-related injuries. Petitioner testified that for each visit he would have to miss a whole day of work.

The Arbitrator finds that Petitioner is not entitled to TTD for these days. Based on the fact that the Petitioner was released to return to work and that the Respondent offered the Petitioner work within his stated restrictions, it is determined that the Petitioner is not entitled to TTD benefits, for these eleven days, under the Illinois Workers' Compensation Act.

It is significant to note that the petitioner testified that each of the appointments were of short duration of time and that there was no evidence presented indicating that the Petitioner was forced to engage in medical treatment during work hours or that the Respondent would not accommodate an alternative work schedule. Nonetheless, based on the facts presented, Petitioner has not proven, by a preponderance of the evidence, that he is entitled to TTD benefits for the eleven days therefore, said claim is denied.

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
12 WC 23126
15IWCC0660 SIGNATURE PAGE

L. Thompson

Signature of Arbitrator

September 10, 2014
Date of Decision

SEP 11 2014

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emily Jacobs,
Petitioner,
vs.

15IWCC0661

NO: 10 WC 14262

Circuit Court of Cook County,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2013 is hereby affirmed and adopted.

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

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

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

DATED: AUG 24 2015
KWL/vf
O-8/10/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0661

JACOBS, EMILY
Employee/Petitioner

Case# 10WC014262

10WC014261

CIRCUIT COURT OF COOK COUNTY
Employer/Respondent

On 9/24/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0132 ASSISTANT STATES ATTORNEY
CYNTHIA ASHFORD
500 DALEY CENTER 5TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

15IWCC0661

Emily Jacobs
Employee/Petitioner

v.

Circuit Court of Cook County
Employer/Respondent

Case # 10 WC 14262

Consolidated cases: 10 WC 14261

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **July 26, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. Was timely notice of the accident given to Respondent? [notice was taken out of dispute at the hearing]
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 **January 13, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident ***was*** given to Respondent. Arb Exh 3. [Notice was taken out of dispute at the hearing, T. 11.]

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

In the year preceding the injury, Petitioner earned $**50,271.00**; the average weekly wage was $**966.75**.

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

Petitioner ***has not*** received 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 as per the stipulation of the parties under Section 8(j) of the Act.

ORDER

The Arbitrator awards no temporary total disability benefits in this case as none of Dr. Mandelin's 2010 "off work" notes reflect he was taking Petitioner off work due to the accident of January 13, 2010. PX 8.

The Arbitrator declines to award medical expenses in this case. Dr. Mandelin did not mention the accident in his note of January 21, 2010. He described Petitioner as voicing bilateral hand complaints that day. He prescribed bilateral hand X-rays and medication but with no reference to an accident. PX 3.

Petitioner failed to establish that the accident of January 13, 2010 resulted in any permanent partial disability. Petitioner testified that her right hand condition returned to baseline following the accident. T. 73. Neither Dr. Kalainov nor Dr. Zindrick expressed awareness of the claimed January 13, 2010 accident. PX 5-6. Respondent's Section 12 examiner, Dr. Heller, described the injury of January 13, 2010 as a clinically insignificant strain.

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

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

Molly C Mason
Signature of Arbitrator

9/24/13
Date

SEP 24 2013

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner, who retired in 2011, testified she was employed as a senior court clerk by Respondent for 23 years. Out of those 23 years, she worked about 19. T. 18. She worked in courtrooms in Respondent's criminal division. She started work at 9 AM and worked straight through until 2 or 2:30 PM. T. 19.

Petitioner testified she used her hands to perform a variety of clerical duties. She is right-handed. T. 21-22. When she first started working for Respondent, in the 1980s, she completed 40 to 60 three-part prisoner data sheets daily. The forms included carbon paper. She testified she had to press hard while writing on the forms. T. 21-22. She also had to complete, stamp, collate and staple a variety of other forms, including half sheets. She estimated she stamped documents about 200 to 300 times each day. T. 24. The stamp she used was heavy. She had to use force to push the handle down. She would operate the stamp with her right hand until her right hand gave out and then use her left hand. T. 26. After she finished her courtroom duties, she would take a break and then pull the court files that would be needed the next two days. Some files were old and weighed three pounds. Others weighed only ounces. T. 28. The oldest files would typically be at the top of a six-foot stack. Since she is 5 feet, 3 inches tall, she would have to reach overhead to retrieve these files. T. 28-29. She would load files into a cart and then pull the cart to the courtroom where she worked. The cart alone weighed 40 to 50 pounds. T. 30. Once she reached the courtroom, she would unload the files. T. 30-31.

Petitioner testified that, beginning in the mid-1990s, her duties changed somewhat as computers came into use. She typically performed data entry for about 1 ½ to 2 hours daily. T. 32. She had to enter each of the judge's orders into the computer. T. 32. The computers were on old benches. They were not equipped with pads. As she typed, her hands would be in front of her, a little below chest level. Her wrists were flexed. She rested her wrists on the wooden surface of the bench. T. 34. She continued to perform data entry in this manner until June of 2007. T. 34.

Petitioner testified that, in 2005 or 2006, she began experiencing tingling in her right ring and small fingers. The tingling went up into her right wrist. Eventually, she began experiencing the same symptoms in her left hand. She continued performing her regular work duties. Her symptoms worsened over time. T. 36-37.

On February 12, 2007, Petitioner consulted Dr. Raby, her primary care physician, in connection with these symptoms. Dr. Raby's note of that date reflects that Petitioner complained of bilateral wrist pain of several weeks' duration. The note also states that Petitioner denied any trauma or precipitating event. The note contains no mention of

Petitioner's work duties. The doctor noted that Petitioner's symptoms worsened when she drove for long periods. The doctor recommended an EMG and bilateral wrist braces. PX 2.

The EMG, performed on February 19, 2007, showed evidence of mild bilateral carpal tunnel syndrome.

On June 7, 2007, Dr. Raby discussed the EMG results with Petitioner and referred her to Dr. Bowen, an orthopedic surgeon. PX 2. There is no evidence indicating Petitioner saw Dr. Bowen.

On June 13, 2007, Petitioner saw Dr. Kalainov, a hand surgeon. Dr. Kalainov's note of that date reflects that Petitioner complained of an insidious onset of numbness in both hands, starting more than two years earlier. The doctor indicated there was "no specific inciting event." Petitioner also reported a gradual onset of bilateral elbow pain.

Dr. Kalainov's note of June 13, 2007 contains no mention of Petitioner's work activities. The doctor noted positive Tinel's over the pronator, cubital tunnel and carpal canal bilaterally. He described Petitioner's presentation as "somewhat atypical" for carpal tunnel syndrome. He injected both carpal canals and prescribed therapy and night wrist splints. PX 1.

Petitioner testified she had a number of supervisors as of June 13, 2007. These supervisors included Robin Sukalo, Larry Zadlo, Tony Tinsley and Mary Mahon. They typically sat together in a big room each day. Petitioner testified she went into this room on June 14, 2007 and reported having been diagnosed with carpal tunnel syndrome. T. 44, 52, 55. She was wearing wrist splints when she made this report. She had been wearing these splints for months prior to June 14, 2007. The splints were not covered up. T. 47. She also reported that the carpal tunnel syndrome stemmed from her work duties. T. 49-50. The supervisors acknowledged her remarks.

Petitioner testified she continued performing full duty thereafter. She remained under Dr. Kalainov's care. She also began seeing Dr. Derwenskus, a neurologist, after a brain MRI showed some abnormalities. T. 58. Petitioner complained to both doctors of various hand and wrist symptoms. On April 28, 2009, Dr. Kalainov noted that Petitioner's symptoms had recently been aggravated by gardening. He recommended a repeat EMG. PX 1.

On May 5, 2009, Petitioner underwent right knee surgery and began a disability leave from work.

On May 25, 2009, Dr. Kalainov informed Petitioner that a repeat EMG performed a week earlier showed no clear evidence of carpal tunnel syndrome. PX 1.

On June 15, 2009, Petitioner informed Dr. Kalainov that her elbows had improved but that her wrist pain persisted. Her symptoms were now worse on the right than the left. The

doctor noted that he informed Petitioner of his "uncertainty regarding the etiology of [her] carpal tunnel symptoms." He referred Petitioner to a rheumatologist. PX 1. RX 5, p. 13.

Petitioner began seeing Dr. Mandelin, a rheumatologist, on July 1, 2009. Dr. Mandelin noted he was seeing Petitioner in consultation "due to repeated migratory inflammatory attacks in her joints." Petitioner complained of numbness and tingling in her fingers as well as pain and swelling in her knees and feet. Petitioner indicated she had been diagnosed with carpal tunnel syndrome and remained symptomatic despite brace usage.

Dr. Mandelin noted that Petitioner had had "positive ANAs at various titers but never any positive 'subtypes.'"

Dr. Mandelin's lengthy note contains no mention of Petitioner's work duties. On examination, he noted no abnormalities other than some bilateral elbow swelling and pain with neck rotation. He indicated that Petitioner's symptoms "argue fairly strongly for inflammatory disease despite negative serologies." He ordered various laboratory studies and started Petitioner on Plaquenil in mid-July 2009.

Petitioner returned to Dr. Mandelin on August 12, 2009. The doctor noted she was "not significantly better" despite having been on Plaquenil for about a month. He noted that Petitioner complained of swelling in her feet and ankles. He also noted that Petitioner "remains on disability due to joint pain." He described Petitioner's complaints as "highly variable" and "not fall[ing] into any predictable pattern."

On re-examination, Dr. Mandelin noted some elbow swelling, right worse than left, right knee pain with varus/valgus stress and flexion and pain with neck rotation.

Dr. Mandelin reiterated that Petitioner's symptoms "argue fairly strongly for inflammatory disease despite negative serologies." He recommended that Petitioner start Mobic, continue the Plaquenil and return to him for Synvisc injections in her knees. PX 3.

At the next visit, on August 26, 2009, Dr. Mandelin noted that Petitioner complained primarily of right ankle swelling but still had some arm pain. On examination, he noted crepitus in both knees and possible positive fibromyalgia tender points at the lateral epicondyle. He instructed Petitioner to continue Mobic. He also indicated Petitioner could consider Synvisc injections for her left knee. PX 3.

On September 16, 2009, Dr. Mandelin injected Petitioner's right knee with Synvisc. He instructed her to return to him in one month for a left knee injection. PX 3.

On October 14, 2009, Petitioner complained to Dr. Mandelin of swelling in both feet and ongoing wrist and elbow symptoms. She indicated she obtained some pain relief from the right knee injection. The doctor noted no convincing positive fibromyalgia tender points on examination. He prescribed medication and a venous ultrasound of the right leg. He also

indicated Petitioner might require a right foot MRI due to chronic swelling. PX 3. The venous ultrasound proved to be negative. RX 4, p. 70.

On December 10, 2009, Petitioner complained to Dr. Mandelin of easy bruising in her right calf and persistent knee swelling. The doctor suggested a trial of Medrol DosePak. He completed "extension of disability" paperwork. PX 3.

Petitioner's knee-related disability leave ended on December 28, 2009. T. 62. She testified she resumed her regular duties at that point. Her hands, wrists and arms worsened while she was on leave. By the time she resumed full duty on December 28, 2009, her hands and wrists were tingling, with the tingling extending up her arms, and both elbows were sore. T. 65.

Petitioner testified she injured her right hand at work on January 13, 2010, while reaching overhead to pull a three-part file out of a tall stack. She managed to get one part of the file down but then dropped it. Another file fell on top of her and struck the palm of her right hand. She grabbed this file with her right hand. Her right hand got very swollen thereafter. T. 66-67. She reported the accident to Robin Sukalo, a supervisor, via telephone. T. 69-70. [Respondent initially disputed notice in this case but amended the Request for Hearing form so as to take notice out of dispute. T. 11. Arb Exh 3. Petitioner testified she managed to finish the workday but her hand was so swollen it looked deformed by the time she went home. T. 71. She was unable to perform her duties the following day. She made an appointment to see Dr. Mandelin. T. 72.

Petitioner returned to Dr. Mandelin on January 21, 2010. T. 72. The doctor's note of that date contains no mention of a specific right hand injury of January 13th. The note sets forth the following history:

> "She is 'bad.' She went back to work for the last 2.5 weeks feels she has aggravated her problem. She has a new c/o B hand pain and swelling, especially on the R (she is rt-handed). Her work involves lifting heavy packs of court documents and fighting with outdated office furniture. Rest relieves her sx. She describes 'shooting' pains and cannot close her rt fist. She especially has trouble with her b thumbs at the bases. Diclofenac is not working at all."

The doctor also indicated:

> "Since her disability was denied, she plans to file for 'injured on duty' due to the mechanism that triggered this flare. She needs paperwork filled out today to recover 3 weeks of lost pay and if this new form of leave is approved she will lose a month's pay before it becomes effective."

Dr. Mandelin obtained bilateral hand and wrist X-rays. The interpreting radiologist noted minor joint space narrowing at the distal articulating margins of the navicular bones and the adjacent trapezium and trapezoid bones at both wrists. He also noted minor metacarpal-phalangeal joint space narrowing at the fifth metacarpal-phalangeal joints at both hands." He saw no evidence of fracture. PX 3.

Dr. Mandelin indicated that Petitioner's "current pattern does look RA-like." He ordered ESR studies. PX 3.

On February 8, 2010, Dr. Mandelin issued a note indicating Petitioner had been "off work for medical reasons" and releasing Petitioner to work on February 10, 2010 with multiple restrictions, including no heavy lifting, "light writing/typing/data entry" and no prolonged repetitive motion. Dr. Mandelin listed the following diagnoses on this note: osteoarthritis, carpal tunnel syndrome, hand pain and joint swelling. PX 8. On February 15, 2010, Dr. Mandelin issued another note restricting Petitioner to "short court calls" of 20 cases or less "in order to permit faster resolution of her condition." PX 8.

At Respondent's request, Petitioner saw Dr. Heller for a Section 12 examination on February 22, 2010. T. 75. Petitioner testified she spent two to three minutes discussing her job duties with Dr. Heller. T. 75. [Dr. Heller's findings and opinions are discussed below].

Petitioner testified that, on March 10, 2010, Dr. Mandelin imposed light duty due to her hand complaints. Petitioner testified that Respondent accommodated Dr. Mandelin's restriction by providing her with a desk job as opposed to her customary courtroom job. The desk job involved writing and performing data entry. T. 77.

On March 16, 2010, Dr. Kalainov noted that Dr. Mandelin "suspect[s] an underlying diagnosis of RA" and recommended Petitioner see him again for a carpal tunnel evaluation before initiating Methotrexate treatment. PX 2.

On March 30, 2010, Dr. Kalainov noted that Petitioner complained of pain in both forearms, wrists and hands and paresthesias in the ulnar three digits of her right hand and the ulnar two digits of his left hand. He also noted that Petitioner "mentioned that she was currently working in a light duty capacity as a court clerk."

On examination, Dr. Kalainov noted full active wrist and finger motion, multiple tender points around the elbows and forearms, pain with grinding maneuvers performed on the thumb basal joints, positive median nerve compression testing over both carpal canals and positive Tinel's with percussion over both elbow cubital tunnels and both wrist carpal tunnels.

Dr. Kalainov's impression was: 1) median neuropathy, bilateral carpal tunnels; 2) ulnar neuropathy, bilateral elbows; 3) basal joint arthritis, both thumbs; and 4) osteoarthritis and possible inflammatory arthropathy. He indicated he informed Petitioner that "peripheral neuropathy symptoms [are] common in association with an inflammatory arthropathy." He

recommended a repeat EMG, continued use of wrist splints at night and a trial of thumb spica splints. PX 1.

On April 14, 2010, Petitioner filed two Applications for Adjustment of Claim. In the Application numbered 10 WC 14261, she alleged bilateral hand and arm injuries of June 13, 2007 secondary to repetitive trauma. Arb Exh 2. In the Application numbered 10 WC 14262, she alleged she injured her right hand and arm on January 13, 2010 while catching a falling court file. Arb Exh 4.

On April 14, 2010, Dr. Mandelin issued a note indicating Petitioner was off work on April 12 and 14, 2010 "due to a flare of her arthritic condition" and would need to remain off work until April 19, 2010. PX 8.

The repeat EMG, performed on May 12, 2010, showed very mild bilateral carpal tunnel syndrome. T. 78.

On May 12, 2010, Dr. Mandelin issued a note indicating Petitioner could return to work immediately but would need to "remain on light duty as currently defined." PX 8.

On May 19, 2010, Dr. Kalainov informed Petitioner of the repeat EMG results. He informed Petitioner that her "hand paresthetic symptoms were more diffuse and pronounced than what [he] would expect from the" EMG. He discussed various treatment options, including surgery, but told Petitioner that carpal tunnel releases "might not reduce or alleviate her paresthetic symptoms." PX 1. Petitioner opted for surgery and, at that time, elected to have her left hand operated on first. T. 78-79.

On June 10, 2010, Petitioner returned to Dr. Kalainov and described her hand symptoms as unchanged. The doctor indicated that Petitioner "brought to [his] attention a few of her current job tasks: writing, occasional use of a computer keyboard" and some of her earlier full duty activities, "including stamping, carrying files, data entry and writing."

The doctor addressed Petitioner's causation-related questions as follows:

> "We discussed several factors associated with carpal tunnel syndrome, including arthritis. She was made aware that repeated impact on the palms and prolonged positions of wrist flexion/extension were associated with increased pressures in the carpal tunnel: activities and wrist positions potentially contributing to carpal tunnel syndrome. I also informed her that task-related factors were variable and inconsistent and the mechanisms by which they might contribute to carpal tunnel syndrome were poorly understood. I stated my opinion that her described activities as a court clerk may have exacerbated

her subjective hand complaints; however, these symptoms would not necessarily equate with a cause or effect."

PX 1.

On August 16, 2010, Dr. Kalainov performed a right carpal tunnel release. Petitioner testified she changed her mind and chose to have the right hand addressed first because that hand was giving her more trouble. T. 79-80. Petitioner underwent occupational therapy following the surgery. Petitioner underwent a left carpal tunnel release on December 10, 2010 and continued seeing Dr. Kalainov thereafter. T. 81.

Petitioner testified that Dr. Kalainov released her to light duty on March 15, 2011. Petitioner further testified she opted to retire at that point because she did not feel her hand condition would allow her to work. T. 82. She has not worked anywhere since she retired. T. 82. She continues to experience tingling and soreness in her ring and small fingers, her wrists and her elbows. She experiences these symptoms daily. The symptoms are aggravated by driving and trying to hold a book. T. 83. She has to switch off hands while driving. She switched from conventional books to a tablet. T. 84.

Petitioner testified her symptoms have stayed the same. She has not sought additional treatment. At her attorney's request, she saw Dr. Zindrick for an evaluation in March of 2013. T. 85. She discussed her job duties with Dr. Zindrick. T. 85.

Under cross-examination, Petitioner acknowledged she did not complete an accident report when she notified her supervisors of her symptoms in 2007. T. 87. She continued performing her job and seeing Dr. Kalainov. T. 88. She completed a disability form in 2007. On this form, she listed all of her medical conditions, including carpal tunnel. T. 88. She did not complete any workers' compensation paperwork. T. 90.

Petitioner testified she did complete an accident report in connection with the hand injury of January 13, 2010.

Petitioner testified that, since her retirement, she has experienced difficulty driving, holding items, washing dishes and sleeping due to her hand condition. T. 98.

Petitioner testified she gardened "a little" in 2008 and gardens "very little" now. T. 99.

On redirect, Petitioner testified that, when she applied to Respondent for disability benefits, she provided what was needed so as to avoid being denied. T. 100. When she circled "no" in response to a question as to whether her disability was work-related, she was responding as to multiple conditions, not just carpal tunnel. T. 101-102. The form she completed called for a "yes/no" response, without further explanation. T. 104. She has difficulty sleeping every night, due to tingling and soreness in her hands. She continues to wear braces on her wrists and elbows at night. T. 105. She also wears these braces when she has to drive a long distance. T. 105-106.

Petitioner offered into evidence a report dated October 20, 2011 authored by Dr. Kalainov. The report reflects that Dr. Kalainov is an associate professor of clinical orthopedic surgery at Northwestern University's Feinberg School of Medicine. In the report, Dr. Kalainov addressed the issue of causation as follows:

> "The development of upper extremity pain and numbness in Ms. Jacob's case may be related to at least four documented conditions, alone or in combination: elbow epicondylitis, fibromyalgia, osteoarthritis and carpal tunnel syndrome. An as yet unidentified inflammatory arthropathy may be a contributing factor. I am uncertain of any possible connection to recent brain MRI study findings that were reportedly assessed by a neurologist, Dr. Joy Denewenskus.
>
> I do not believe that repetitive activities caused carpal tunnel syndrome in Ms. Jacobs' case. Most task-related factors are variable and inconsistent, and the mechanisms by which they might contribute to carpal tunnel syndrome are poorly understood. potential risk factors for carpal tunnel syndrome in Ms. Jacobs' case include female gender, advancing age, basal joint arthritis and a bifid median nerve. Furthermore, I do not believe that repetitive activities caused elbow epicondylitis or thumb arthritis as both of these conditions are common with advancing age. Nevertheless, writing and use of a computer keyboard may have certainly aggravated Ms. Jacobs' symptoms of upper extremity pain and numbness."

PX 5.

Petitioner also offered into evidence a report authored by Dr. Zindrick on March 21, 2013. Dr. Zindrick is associated with Hinsdale Orthopaedics.

In his report, Dr. Zindrick indicated he examined Petitioner and reviewed records from Drs. Raby, Kalainov, Dermenskus, Barr, Mandelin, Heller and Marks along with an EMG report, an MRI report and the operative reports.

Dr. Zindrick's description of the duration and nature of Petitioner's courtroom duties is consistent with Petitioner's testimony. He noted she performed these duties for 19 years. He also noted she retired in 2011 but recently noticed worsening of her hand, wrist and elbow symptoms.

On examination, Dr. Zindrick noted healed scars on the volar aspects of both wrists, positive Phalen's and Tinel's at both wrists, tenderness over the lateral and medial epicondyle bilaterally, no motor weakness and no muscle wasting or atrophy.

Dr. Zindrick opined, within a reasonable degree of medical and surgical certainty, that Petitioner's court clerk duties were a "confident cause" of her carpal tunnel syndrome and epicondylitis. He further opined that, although there are other causes for both of these conditions, Petitioner's job was a "significant contributing factor to the onset of her symptoms and persistent problems resulting in the treatment she has received." PX 6.

The reports authored by Drs. Kalainov and Zindrick contain no mention of Petitioner's claimed work accident of January 13, 2010.

Petitioner also offered into evidence a group of medical bills totaling $103,809.28. The Arbitrator notes that the claimed bills include expenses for multiple brain MRIs, lumbar punctures and other studies ordered by Dr. Derwenskus from 2007 forward. PX 7.

No witnesses testified on behalf of Respondent. Respondent offered into evidence Dr. Heller's Section 12 examination report of February 22, 2010. In that report, Dr. Heller described Petitioner as having "longstanding complaints" relating to both arms and both legs. He noted that Petitioner reported injuring her right hand and wrist while grabbing a falling file on January 13, 2010. He noted that Petitioner had been off work since this incident.

Dr. Heller noted no evidence of rheumatoid arthritis or other abnormalities on examination. He indicated that median nerve compression testing was negative for carpal tunnel syndrome. He indicated that grip strength testing showed maximal 25 pounds in Petitioner's non-dominant left hand and 15 pounds in her right hand. He stated that this testing failed to show a bell-shaped curve "which is typically indicative of submaximal effort."

Dr. Heller indicated he reviewed various X-ray reports. The only abnormality he noted in the reports was "some mild early degenerative changes at the thumb CMC joint."

Dr. Heller concluded that the injury Petitioner sustained on January 13, 2010 was a "mild right wrist or hand sprain without any significant musculoskeletal ramification." He further opined that the January 13, 2010 accident did not result in any significant worsening of Petitioner's pre-existing carpal tunnel syndrome and/or rheumatologic complaints. He described the sprain as "clinically insignificant."

Dr. Heller recommended that Petitioner continue treating with her rheumatologist but he did not view this treatment as stemming from any work accident or work-related condition. He attributed Petitioner's inability to work to her "underlying rheumatologic condition and carpal tunnel syndrome that clearly pre-existed" January 13, 2010. He did not believe that Petitioner required any restrictions relative to the injury of January 13, 2010. He found Petitioner to be at maximum medical improvement from that injury. RX 3.

Respondent also offered into evidence an Application for Extension of Disability Benefits completed by Petitioner on November 1, 2010. The following question and response appear on this form:

> "7. If you do not claim that your disability is due to injury incurred while in the performance of duty, give a a statement as to the nature and probable cause of your disability as they appear to you.
>
> Have bunions and hammertoes on both right and left feet and toes; carpal tunnel rt left."

RX 1. An Attending Physician's Statement of Disability in RX 1 reflects that Dr. Mandelin answered "yes" in response to a question as to whether Petitioner's various diagnoses, including carpal tunnel, were work-related.

Respondent also offered into evidence an Attending Physician's Statement of Disability signed by Dr. Kalainov indicating he had last seen Petitioner on December 10, 2010 and that Petitioner's left carpal tunnel syndrome was not work-related. RX 2.

[CONT'D]

Arbitrator's Conclusions of Law Relative to 10 WC 14262

Did Petitioner sustain an accident on January 13, 2010 arising out of and in the course of her employment?

Petitioner testified that, on January 13, 2010, she was reaching overhead, trying to extricate a three-part file from a stack of files, when she lost her grip on one file, causing another file to fall and strike the open palm of her right hand. Petitioner testified she noticed swelling in her right hand after this accident. T. 66. She notified a supervisor of the accident via telephone and later completed an accident report. T. 68-70. [At the hearing, Respondent amended the stipulation sheet so as to take notice out of dispute, T. 11, Arb Exh 3].

No Respondent witness contradicted Petitioner's account of the accident. Petitioner credibly testified the accident occurred in one of Respondent's courtrooms while she was performing her typical duties during her regular work hours.

Based on Petitioner's testimony, the Arbitrator finds that Petitioner sustained an accident on January 13, 2010 arising out of and in the course of her employment.

Did Petitioner establish a causal connection between the accident of January 13, 2010 and her claimed current conditions of ill-being?

The Arbitrator finds that Petitioner failed to establish a causal connection between the file-related accident of January 13, 2010 and any claimed current condition of ill-being. The only physician who specifically mentioned the accident is Respondent's examiner, Dr. Heller. Dr. Heller described the accident as resulting in an insignificant strain. RX 3. Petitioner acknowledged that her right hand symptoms returned to baseline following the accident. Drs. Kalainov and Zindrick, the physicians who commented on causation in the companion repetitive trauma case, numbered 10 WC 14261, did not express awareness of the January 13, 2010 accident, let alone target it as a cause of Petitioner's claimed bilateral carpal tunnel and epicondylitis.

Is Petitioner entitled to temporary total disability benefits? Is Petitioner entitled to medical expenses? Is Petitioner entitled to permanency?

The Arbitrator awards no benefits in this case. Petitioner testified she was unable to work after the accident but she acknowledged she did not seek treatment until January 21, 2010. Dr. Mandelin's note of that date does not mention the accident. The note does reflect that Petitioner complained of worsening hand symptoms stemming from work duties, including "lifting heavy packs of court documents," but the complaints were relative to both hands, not just the right. Dr. Mandelin did not prescribe any treatment specific to a right hand injury. Dr. Mandelin did take Petitioner off work at various points after January 13, 2010 but his "off work" notes of February 8 and April 14, 2010 reference arthritis and/or carpal tunnel as the cause of

the lost time. PX 8. Petitioner did not offer any evidence indicating that Dr. Mandelin kept her off work as a result of the January 13, 2010 accident. Petitioner did not testify that the accident resulted in any permanent worsening of her already-existing right hand symptoms. Nor did Petitioner offer any opinion indicating that the accident of January 13, 2010 resulted in any permanent partial right hand disability.

Compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Emily Jacobs,
Petitioner,
vs.

15IWCC0662

NO: 10 WC 14261

Circuit Court of Cook County,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 24, 2013 is hereby affirmed and adopted.

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

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

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

DATED: AUG 24 2015
KWL/vf
O-8/10/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

15IWCC0662

JACOBS, EMILY
Employee/Petitioner

Case# **10WC014261**

10WC014262

CIRCUIT COURT OF COOK COUNTY
Employer/Respondent

On 9/24/2013, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0311 KOSIN LAW OFFICE LTD
DAVID X KOSIN
134 N LASALLE ST SUITE 1340
CHICAGO, IL 60602

0132 ASSISTANT STATES ATTORNEY
CYNTHIA ASHFORD
500 DALEY CENTER 5TH FL
CHICAGO, IL 60602

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION 15IWCC0662

EMILY JACOBS
Employee/Petitioner

v.

CIRCUIT COURT OF COOK COUNTY
Employer/Respondent

Case # 10 WC 14261

Consolidated cases: 10 WC 14262

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MOLLY MASON**, Arbitrator of the Commission, in the city of **CHICAGO**, on **JULY 26, 2013**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0662

FINDINGS

On **06/13/07**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain repetitive trauma injuries arising out of and in the course of employment.

Petitioner failed to establish a causal connection as to her claimed current conditions of bilateral carpal tunnel syndrome and epicondylitis.

In light of the foregoing findings, the Arbitrator finds it unnecessary to address the remaining disputed issues.

In the year preceding the injury, Petitioner earned $**50,271.00**; the average weekly wage was $**966.75**.

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

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

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

ORDER

This Arbitrator finds that Petitioner lacked credibility and failed to prove repetitive trauma and causal connection. In light of this, the Arbitrator finds it unnecessary to address the remaining disputed issues. Compensation is denied.

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

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

Molly C Mason
Signature of Arbitrator

9/24/13
Date

SEP 24 2013

Emily Jacobs v. Circuit Court of Cook County
10 WC 14261-2 (consolidated)

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner, who retired in 2011, testified she was employed as a senior court clerk by Respondent for 23 years. Out of those 23 years, she worked about 19. T. 18. She worked in courtrooms in Respondent's criminal division. She started work at 9 AM and worked straight through until 2 or 2:30 PM. T. 19.

Petitioner testified she used her hands to perform a variety of clerical duties. She is right-handed. T. 21-22. When she first started working for Respondent, in the 1980s, she completed 40 to 60 three-part prisoner data sheets daily. The forms included carbon paper. She testified she had to press hard while writing on the forms. T. 21-22. She also had to complete, stamp, collate and staple a variety of other forms, including half sheets. She estimated she stamped documents about 200 to 300 times each day. T. 24. The stamp she used was heavy. She had to use force to push the handle down. She would operate the stamp with her right hand until her right hand gave out and then use her left hand. T. 26. After she finished her courtroom duties, she would take a break and then pull the court files that would be needed the next two days. Some files were old and weighed three pounds. Others weighed only ounces. T. 28. The oldest files would typically be at the top of a six-foot stack. Since she is 5 feet, 3 inches tall, she would have to reach overhead to retrieve these files. T. 28-29. She would load files into a cart and then pull the cart to the courtroom where she worked. The cart alone weighed 40 to 50 pounds. T. 30. Once she reached the courtroom, she would unload the files. T. 30-31.

Petitioner testified that, beginning in the mid-1990s, her duties changed somewhat as computers came into use. She typically performed data entry for about 1 ½ to 2 hours daily. T. 32. She had to enter each of the judge's orders into the computer. T. 32. The computers were on old benches. They were not equipped with pads. As she typed, her hands would be in front of her, a little below chest level. Her wrists were flexed. She rested her wrists on the wooden surface of the bench. T. 34. She continued to perform data entry in this manner until June of 2007. T. 34.

Petitioner testified that, in 2005 or 2006, she began experiencing tingling in her right ring and small fingers. The tingling went up into her right wrist. Eventually, she began experiencing the same symptoms in her left hand. She continued performing her regular work duties. Her symptoms worsened over time. T. 36-37.

On February 12, 2007, Petitioner consulted Dr. Raby, her primary care physician, in connection with these symptoms. Dr. Raby's note of that date reflects that Petitioner complained of bilateral wrist pain of several weeks' duration. The note also states that Petitioner denied any trauma or precipitating event. The note contains no mention of

Petitioner's work duties. The doctor noted that Petitioner's symptoms worsened when she drove for long periods. The doctor recommended an EMG and bilateral wrist braces. PX 2.

The EMG, performed on February 19, 2007, showed evidence of mild bilateral carpal tunnel syndrome.

On June 7, 2007, Dr. Raby discussed the EMG results with Petitioner and referred her to Dr. Bowen, an orthopedic surgeon. PX 2. There is no evidence indicating Petitioner saw Dr. Bowen.

On June 13, 2007, Petitioner saw Dr. Kalainov, a hand surgeon. Dr. Kalainov's note of that date reflects that Petitioner complained of an insidious onset of numbness in both hands, starting more than two years earlier. The doctor indicated there was "no specific inciting event." Petitioner also reported a gradual onset of bilateral elbow pain.

Dr. Kalainov's note of June 13, 2007 contains no mention of Petitioner's work activities. The doctor noted positive Tinel's over the pronator, cubital tunnel and carpal canal bilaterally. He described Petitioner's presentation as "somewhat atypical" for carpal tunnel syndrome. He injected both carpal canals and prescribed therapy and night wrist splints. PX 1.

Petitioner testified she had a number of supervisors as of June 13, 2007. These supervisors included Robin Sukalo, Larry Zadlo, Tony Tinsley and Mary Mahon. They typically sat together in a big room each day. Petitioner testified she went into this room on June 14, 2007 and reported having been diagnosed with carpal tunnel syndrome. T. 44, 52, 55. She was wearing wrist splints when she made this report. She had been wearing these splints for months prior to June 14, 2007. The splints were not covered up. T. 47. She also reported that the carpal tunnel syndrome stemmed from her work duties. T. 49-50. The supervisors acknowledged her remarks.

Petitioner testified she continued performing full duty thereafter. She remained under Dr. Kalainov's care. She also began seeing Dr. Derwenskus, a neurologist, after a brain MRI showed some abnormalities. T. 58. Petitioner complained to both doctors of various hand and wrist symptoms. On April 28, 2009, Dr. Kalainov noted that Petitioner's symptoms had recently been aggravated by gardening. He recommended a repeat EMG. PX 1.

On May 5, 2009, Petitioner underwent right knee surgery and began a disability leave from work.

On May 25, 2009, Dr. Kalainov informed Petitioner that a repeat EMG performed a week earlier showed no clear evidence of carpal tunnel syndrome. PX 1.

On June 15, 2009, Petitioner informed Dr. Kalainov that her elbows had improved but that her wrist pain persisted. Her symptoms were now worse on the right than the left. The

doctor noted that he informed Petitioner of his "uncertainty regarding the etiology of [her] carpal tunnel symptoms." He referred Petitioner to a rheumatologist. PX 1. RX 5, p. 13.

Petitioner began seeing Dr. Mandelin, a rheumatologist, on July 1, 2009. Dr. Mandelin noted he was seeing Petitioner in consultation "due to repeated migratory inflammatory attacks in her joints." Petitioner complained of numbness and tingling in her fingers as well as pain and swelling in her knees and feet. Petitioner indicated she had been diagnosed with carpal tunnel syndrome and remained symptomatic despite brace usage.

Dr. Mandelin noted that Petitioner had had "positive ANAs at various titers but never any positive 'subtypes.'"

Dr. Mandelin's lengthy note contains no mention of Petitioner's work duties. On examination, he noted no abnormalities other than some bilateral elbow swelling and pain with neck rotation. He indicated that Petitioner's symptoms "argue fairly strongly for inflammatory disease despite negative serologies." He ordered various laboratory studies and started Petitioner on Plaquenil in mid-July 2009.

Petitioner returned to Dr. Mandelin on August 12, 2009. The doctor noted she was "not significantly better" despite having been on Plaquenil for about a month. He noted that Petitioner complained of swelling in her feet and ankles. He also noted that Petitioner "remains on disability due to joint pain." He described Petitioner's complaints as "highly variable" and "not fall[ing] into any predictable pattern."

On re-examination, Dr. Mandelin noted some elbow swelling, right worse than left, right knee pain with varus/valgus stress and flexion and pain with neck rotation.

Dr. Mandelin reiterated that Petitioner's symptoms "argue fairly strongly for inflammatory disease despite negative serologies." He recommended that Petitioner start Mobic, continue the Plaquenil and return to him for Synvisc injections in her knees. PX 3.

At the next visit, on August 26, 2009, Dr. Mandelin noted that Petitioner complained primarily of right ankle swelling but still had some arm pain. On examination, he noted crepitus in both knees and possible positive fibromyalgia tender points at the lateral epicondyle. He instructed Petitioner to continue Mobic. He also indicated Petitioner could consider Synvisc injections for her left knee. PX 3.

On September 16, 2009, Dr. Mandelin injected Petitioner's right knee with Synvisc. He instructed her to return to him in one month for a left knee injection. PX 3.

On October 14, 2009, Petitioner complained to Dr. Mandelin of swelling in both feet and ongoing wrist and elbow symptoms. She indicated she obtained some pain relief from the right knee injection. The doctor noted no convincing positive fibromyalgia tender points on examination. He prescribed medication and a venous ultrasound of the right leg. He also

indicated Petitioner might require a right foot MRI due to chronic swelling. PX 3. The venous ultrasound proved to be negative. RX 4, p. 70.

On December 10, 2009, Petitioner complained to Dr. Mandelin of easy bruising in her right calf and persistent knee swelling. The doctor suggested a trial of Medrol DosePak. He completed "extension of disability" paperwork. PX 3.

Petitioner's knee-related disability leave ended on December 28, 2009. T. 62. She testified she resumed her regular duties at that point. Her hands, wrists and arms worsened while she was on leave. By the time she resumed full duty on December 28, 2009, her hands and wrists were tingling, with the tingling extending up her arms, and both elbows were sore. T. 65.

Petitioner testified she injured her right hand at work on January 13, 2010, while reaching overhead to pull a three-part file out of a tall stack. She managed to get one part of the file down but then dropped it. Another file fell on top of her and struck the palm of her right hand. She grabbed this file with her right hand. Her right hand got very swollen thereafter. T. 66-67. She reported the accident to Robin Sukalo, a supervisor, via telephone. T. 69-70. [Respondent initially disputed notice in this case but amended the Request for Hearing form so as to take notice out of dispute. T. 11. Arb Exh 3. Petitioner testified she managed to finish the workday but her hand was so swollen it looked deformed by the time she went home. T. 71. She was unable to perform her duties the following day. She made an appointment to see Dr. Mandelin. T. 72.

Petitioner returned to Dr. Mandelin on January 21, 2010. T. 72. The doctor's note of that date contains no mention of a specific right hand injury of January 13th. The note sets forth the following history:

> "She is 'bad.' She went back to work for the last 2.5 weeks feels she has aggravated her problem. She has a new c/o B hand pain and swelling, especially on the R (she is rt-handed). Her work involves lifting heavy packs of court documents and fighting with outdated office furniture. Rest relieves her sx. She describes 'shooting' pains and cannot close her rt fist. She especially has trouble with her b thumbs at the bases. Diclofenac is not working at all."

The doctor also indicated:

> "Since her disability was denied, she plans to file for 'injured on duty' due to the mechanism that triggered this flare. She needs paperwork filled out today to recover 3 weeks of lost pay and if this new form of leave is approved she will lose a month's pay before it becomes effective."

Dr. Mandelin obtained bilateral hand and wrist X-rays. The interpreting radiologist noted minor joint space narrowing at the distal articulating margins of the navicular bones and the adjacent trapezium and trapezoid bones at both wrists. He also noted minor metacarpal-phalangeal joint space narrowing at the fifth metacarpal-phalangeal joints at both hands." He saw no evidence of fracture. PX 3.

Dr. Mandelin indicated that Petitioner's "current pattern does look RA-like." He ordered ESR studies. PX 3.

On February 8, 2010, Dr. Mandelin issued a note indicating Petitioner had been "off work for medical reasons" and releasing Petitioner to work on February 10, 2010 with multiple restrictions, including no heavy lifting, "light writing/typing/data entry" and no prolonged repetitive motion. Dr. Mandelin listed the following diagnoses on this note: osteoarthritis, carpal tunnel syndrome, hand pain and joint swelling. PX 8. On February 15, 2010, Dr. Mandelin issued another note restricting Petitioner to "short court calls" of 20 cases or less "in order to permit faster resolution of her condition." PX 8.

At Respondent's request, Petitioner saw Dr. Heller for a Section 12 examination on February 22, 2010. T. 75. Petitioner testified she spent two to three minutes discussing her job duties with Dr. Heller. T. 75. [Dr. Heller's findings and opinions are discussed below].

Petitioner testified that, on March 10, 2010, Dr. Mandelin imposed light duty due to her hand complaints. Petitioner testified that Respondent accommodated Dr. Mandelin's restriction by providing her with a desk job as opposed to her customary courtroom job. The desk job involved writing and performing data entry. T. 77.

On March 16, 2010, Dr. Kalainov noted that Dr. Mandelin "suspect[s] an underlying diagnosis of RA" and recommended Petitioner see him again for a carpal tunnel evaluation before initiating Methotrexate treatment. PX 2.

On March 30, 2010, Dr. Kalainov noted that Petitioner complained of pain in both forearms, wrists and hands and paresthesias in the ulnar three digits of her right hand and the ulnar two digits of his left hand. He also noted that Petitioner "mentioned that she was currently working in a light duty capacity as a court clerk."

On examination, Dr. Kalainov noted full active wrist and finger motion, multiple tender points around the elbows and forearms, pain with grinding maneuvers performed on the thumb basal joints, positive median nerve compression testing over both carpal canals and positive Tinel's with percussion over both elbow cubital tunnels and both wrist carpal tunnels.

Dr. Kalainov's impression was: 1) median neuropathy, bilateral carpal tunnels; 2) ulnar neuropathy, bilateral elbows; 3) basal joint arthritis, both thumbs; and 4) osteoarthritis and possible inflammatory arthropathy. He indicated he informed Petitioner that "peripheral neuropathy symptoms [are] common in association with an inflammatory arthropathy." He

recommended a repeat EMG, continued use of wrist splints at night and a trial of thumb spica splints. PX 1.

On April 14, 2010, Petitioner filed two Applications for Adjustment of Claim. In the Application numbered 10 WC 14261, she alleged bilateral hand and arm injuries of June 13, 2007 secondary to repetitive trauma. Arb Exh 2. In the Application numbered 10 WC 14262, she alleged she injured her right hand and arm on January 13, 2010 while catching a falling court file. Arb Exh 4.

On April 14, 2010, Dr. Mandelin issued a note indicating Petitioner was off work on April 12 and 14, 2010 "due to a flare of her arthritic condition" and would need to remain off work until April 19, 2010. PX 8.

The repeat EMG, performed on May 12, 2010, showed very mild bilateral carpal tunnel syndrome. T. 78.

On May 12, 2010, Dr. Mandelin issued a note indicating Petitioner could return to work immediately but would need to "remain on light duty as currently defined." PX 8.

On May 19, 2010, Dr. Kalainov informed Petitioner of the repeat EMG results. He informed Petitioner that her "hand paresthetic symptoms were more diffuse and pronounced than what [he] would expect from the" EMG. He discussed various treatment options, including surgery, but told Petitioner that carpal tunnel releases "might not reduce or alleviate her paresthetic symptoms." PX 1. Petitioner opted for surgery and, at that time, elected to have her left hand operated on first. T. 78-79.

On June 10, 2010, Petitioner returned to Dr. Kalainov and described her hand symptoms as unchanged. The doctor indicated that Petitioner "brought to [his] attention a few of her current job tasks: writing, occasional use of a computer keyboard" and some of her earlier full duty activities, "including stamping, carrying files, data entry and writing."

The doctor addressed Petitioner's causation-related questions as follows:

> "We discussed several factors associated with carpal tunnel syndrome, including arthritis. She was made aware that repeated impact on the palms and prolonged positions of wrist flexion/extension were associated with increased pressures in the carpal tunnel: activities and wrist positions potentially contributing to carpal tunnel syndrome. I also informed her that task-related factors were variable and inconsistent and the mechanisms by which they might contribute to carpal tunnel syndrome were poorly understood. I stated my opinion that her described activities as a court clerk may have exacerbated

her subjective hand complaints; however, these symptoms would not necessarily equate with a cause or effect."

PX 1.

On August 16, 2010, Dr. Kalainov performed a right carpal tunnel release. Petitioner testified she changed her mind and chose to have the right hand addressed first because that hand was giving her more trouble. T. 79-80. Petitioner underwent occupational therapy following the surgery. Petitioner underwent a left carpal tunnel release on December 10, 2010 and continued seeing Dr. Kalainov thereafter. T. 81.

Petitioner testified that Dr. Kalainov released her to light duty on March 15, 2011. Petitioner further testified she opted to retire at that point because she did not feel her hand condition would allow her to work. T. 82. She has not worked anywhere since she retired. T. 82. She continues to experience tingling and soreness in her ring and small fingers, her wrists and her elbows. She experiences these symptoms daily. The symptoms are aggravated by driving and trying to hold a book. T. 83. She has to switch off hands while driving. She switched from conventional books to a tablet. T. 84.

Petitioner testified her symptoms have stayed the same. She has not sought additional treatment. At her attorney's request, she saw Dr. Zindrick for an evaluation in March of 2013. T. 85. She discussed her job duties with Dr. Zindrick. T. 85.

Under cross-examination, Petitioner acknowledged she did not complete an accident report when she notified her supervisors of her symptoms in 2007. T. 87. She continued performing her job and seeing Dr. Kalainov. T. 88. She completed a disability form in 2007. On this form, she listed all of her medical conditions, including carpal tunnel. T. 88. She did not complete any workers' compensation paperwork. T. 90.

Petitioner testified she did complete an accident report in connection with the hand injury of January 13, 2010.

Petitioner testified that, since her retirement, she has experienced difficulty driving, holding items, washing dishes and sleeping due to her hand condition. T. 98.

Petitioner testified she gardened "a little" in 2008 and gardens "very little" now. T. 99.

On redirect, Petitioner testified that, when she applied to Respondent for disability benefits, she provided what was needed so as to avoid being denied. T. 100. When she circled "no" in response to a question as to whether her disability was work-related, she was responding as to multiple conditions, not just carpal tunnel. T. 101-102. The form she completed called for a "yes/no" response, without further explanation. T. 104. She has difficulty sleeping every night, due to tingling and soreness in her hands. She continues to wear braces on her wrists and elbows at night. T. 105. She also wears these braces when she has to drive a long distance. T. 105-106.

Petitioner offered into evidence a report dated October 20, 2011 authored by Dr. Kalainov. The report reflects that Dr. Kalainov is an associate professor of clinical orthopedic surgery at Northwestern University's Feinberg School of Medicine. In the report, Dr. Kalainov addressed the issue of causation as follows:

> "The development of upper extremity pain and numbness in Ms. Jacob's case may be related to at least four documented conditions, alone or in combination: elbow epicondylitis, fibromyalgia, osteoarthritis and carpal tunnel syndrome. An as yet unidentified inflammatory arthropathy may be a contributing factor. I am uncertain of any possible connection to recent brain MRI study findings that were reportedly assessed by a neurologist, Dr. Joy Denewenskus.
>
> I do not believe that repetitive activities caused carpal tunnel syndrome in Ms. Jacobs' case. Most task-related factors are variable and inconsistent, and the mechanisms by which they might contribute to carpal tunnel syndrome are poorly understood. potential risk factors for carpal tunnel syndrome in Ms. Jacobs' case include female gender, advancing age, basal joint arthritis and a bifid median nerve. Furthermore, I do not believe that repetitive activities caused elbow epicondylitis or thumb arthritis as both of these conditions are common with advancing age. Nevertheless, writing and use of a computer keyboard may have certainly aggravated Ms. Jacobs' symptoms of upper extremity pain and numbness."

PX 5.

Petitioner also offered into evidence a report authored by Dr. Zindrick on March 21, 2013. Dr. Zindrick is associated with Hinsdale Orthopaedics.

In his report, Dr. Zindrick indicated he examined Petitioner and reviewed records from Drs. Raby, Kalainov, Dermenskus, Barr, Mandelin, Heller and Marks along with an EMG report, an MRI report and the operative reports.

Dr. Zindrick's description of the duration and nature of Petitioner's courtroom duties is consistent with Petitioner's testimony. He noted she performed these duties for 19 years. He also noted she retired in 2011 but recently noticed worsening of her hand, wrist and elbow symptoms.

On examination, Dr. Zindrick noted healed scars on the volar aspects of both wrists, positive Phalen's and Tinel's at both wrists, tenderness over the lateral and medial epicondyle bilaterally, no motor weakness and no muscle wasting or atrophy.

Dr. Zindrick opined, within a reasonable degree of medical and surgical certainty, that Petitioner's court clerk duties were a "confident cause" of her carpal tunnel syndrome and epicondylitis. He further opined that, although there are other causes for both of these conditions, Petitioner's job was a "significant contributing factor to the onset of her symptoms and persistent problems resulting in the treatment she has received." PX 6.

The reports authored by Drs. Kalainov and Zindrick contain no mention of Petitioner's claimed work accident of January 13, 2010.

Petitioner also offered into evidence a group of medical bills totaling $103,809.28. The Arbitrator notes that the claimed bills include expenses for multiple brain MRIs, lumbar punctures and other studies ordered by Dr. Derwenskus from 2007 forward. PX 7.

No witnesses testified on behalf of Respondent. Respondent offered into evidence Dr. Heller's Section 12 examination report of February 22, 2010. In that report, Dr. Heller described Petitioner as having "longstanding complaints" relating to both arms and both legs. He noted that Petitioner reported injuring her right hand and wrist while grabbing a falling file on January 13, 2010. He noted that Petitioner had been off work since this incident.

Dr. Heller noted no evidence of rheumatoid arthritis or other abnormalities on examination. He indicated that median nerve compression testing was negative for carpal tunnel syndrome. He indicated that grip strength testing showed maximal 25 pounds in Petitioner's non-dominant left hand and 15 pounds in her right hand. He stated that this testing failed to show a bell-shaped curve "which is typically indicative of submaximal effort."

Dr. Heller indicated he reviewed various X-ray reports. The only abnormality he noted in the reports was "some mild early degenerative changes at the thumb CMC joint."

Dr. Heller concluded that the injury Petitioner sustained on January 13, 2010 was a "mild right wrist or hand sprain without any significant musculoskeletal ramification." He further opined that the January 13, 2010 accident did not result in any significant worsening of Petitioner's pre-existing carpal tunnel syndrome and/or rheumatologic complaints. He described the sprain as "clinically insignificant."

Dr. Heller recommended that Petitioner continue treating with her rheumatologist but he did not view this treatment as stemming from any work accident or work-related condition. He attributed Petitioner's inability to work to her "underlying rheumatologic condition and carpal tunnel syndrome that clearly pre-existed" January 13, 2010. He did not believe that Petitioner required any restrictions relative to the injury of January 13, 2010. He found Petitioner to be at maximum medical improvement from that injury. RX 3.

Respondent also offered into evidence an Application for Extension of Disability Benefits completed by Petitioner on November 1, 2010. The following question and response appear on this form:

> "7. If you do not claim that your disability is due to injury incurred while in the performance of duty, give a a statement as to the nature and probable cause of your disability as they appear to you.
>
> Have bunions and hammertoes on both right and left feet and toes; carpal tunnel rt left."

RX 1. An Attending Physician's Statement of Disability in RX 1 reflects that Dr. Mandelin answered "yes" in response to a question as to whether Petitioner's various diagnoses, including carpal tunnel, were work-related.

Respondent also offered into evidence an Attending Physician's Statement of Disability signed by Dr. Kalainov indicating he had last seen Petitioner on December 10, 2010 and that Petitioner's left carpal tunnel syndrome was not work-related. RX 2.

[CONT'D]

Emily Jacobs v. Circuit Court of Cook County
10 WC 14261-2 (consolidated)

Arbitrator's Credibility Assessment and Conclusions of Law Relative to 10 WC 14261

Did Petitioner establish repetitive trauma injuries manifesting themselves on June 13, 2007? Did Petitioner establish a causal connection between those claimed injuries and her claimed current bilateral carpal tunnel syndrome and epicondylitis conditions of ill-being? Did Petitioner provide timely notice?

The Arbitrator finds that Petitioner lacked credibility and failed to meet her burden of proof on the issues of accident and causation. No Respondent witness contradicted Petitioner's notice-related testimony but the Arbitrator is unable to reconcile that testimony with Petitioner's medical records.

Petitioner alleges that her claimed current hand and elbow conditions of ill-being stem from the clerical duties she performed for Respondent. Petitioner also alleges a manifestation date of June 13, 2007. Petitioner provided detailed testimony about her duties and indicated she drew a link between those duties and her symptoms on June 13, 2007, the day before she allegedly told a group of Respondent supervisors that she had carpal tunnel syndrome and that this condition stemmed from her work. Petitioner's testimony as to her mindset on June 13, 2007 is very much at odds with the history Dr. Kalainov recorded that day. Dr. Kalainov indicated that Petitioner "mentioned no specific inciting event" as a cause of her hand and elbow symptoms. [Dr. Kalainov's history is consistent with that recorded by Dr. Raby four months earlier. On February 20, 2007, Dr. Raby described Petitioner as complaining of bilateral wrist pain, with "no trauma or precipitating event." PX 2] On April 28, 2009, Dr. Kalainov noted that Petitioner attributed a recent aggravation of her symptoms to gardening. In June of 2009, Dr. Kalainov described the etiology of Petitioner's symptoms as "unclear." It was not until June 10, 2010, three years after the alleged manifestation date, that Dr. Kalainov described Petitioner as attempting to draw a link between her symptoms and her job duties. In his June 10, 2010 note, Dr. Kalainov indicated Petitioner "**brought to [his] attention** a few of her current job tasks" and some of her earlier full duty activities. (emphasis added) Complicating matters further is the fact that Petitioner's diagnosis was less than certain during the period in question. While Petitioner was seeing Dr. Kalainov between 2007 and 2010, she was also undergoing work-ups with several other physicians for brain lesions/possible multiple sclerosis and rheumatoid arthritis.

If, as of June 13, 2007, Petitioner was possessed of sufficient information to be able to tell her supervisors she had work-related carpal tunnel syndrome, why would that same information not appear in her contemporaneous medical records? And why would Petitioner have lumped her hand and arm conditions in with other health conditions when she applied to Respondent for non-occupational disability benefits?

In support of her claim, Petitioner offered reports from Dr. Kalainov and her examining physician, Dr. Zindrick. Dr. Kalainov identified various possible systemic causes of Petitioner's upper extremity symptoms. He viewed Petitioner's work activities as possibly aggravating her hand and elbow symptoms but not causing her condition. PX 5. Dr. Zindrick opined that Petitioner's work activities were a cause of her carpal tunnel and epicondylitis but he did not explain the basis for this opinion. PX 6. The Arbitrator finds Dr. Zindrick unpersuasive. The Arbitrator also notes that Dr. Zindrick described Petitioner as more symptomatic since her 2011 retirement. If the work activities were a cause of Petitioner's condition, it would seem she would have improved rather than worsened once she left the work environment.

Compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

☒ Affirm and adopt	☐ Injured Workers' Benefit Fund (§4(d))
☐ Affirm with changes	☐ Rate Adjustment Fund (§8(g))
☐ Reverse	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

15IWCC0663

Hortensia Cartlidge,
Petitioner,
vs.

NO: 07 WC 44849

Illinois Secretary of State,
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, medical expenses, notice permanent partial disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 11, 2014 is hereby affirmed and adopted.

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

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

DATED: AUG 2 4 2015
KWL/vf
O-8/11/15
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

15IWCC0663

CARTLIDGE, HORTENSIA
Employee/Petitioner

Case# **07WC044849**

07WC044850

ILLINOIS SECRETARY OF STATE
Employer/Respondent

On 9/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.04% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0222 GOLDBERG WEISMAN & CAIRO LTD
DEBORAH BAKER
ONE E WACKER DR 39TH FL
CHICAGO, IL 60601

5132 ASSISTANT ATTORNEY GENERAL
STACEY R LASKIN
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601-3227

0502 ST EMPLOYMENT RETIREMENT SYSTEMS
2101 S VETERANS PARKWAY*
PO BOX 19255
SPRINGFIELD, IL 62794-9255

0499 DEPT OF CENTRAL MGMT SERVICES
MGR WORKMENS COMP RISK MGMT
801 S SEVENTH ST 6 MAIN
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

SEP 11 2014

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

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

CORRECTED ARBITRATION DECISION

15IWCC0663

HORTENSIA CARTLIDGE
Employee/Petitioner

Case #07 WC 44849
#07 WC 44850

v.

ILLINOIS SECRETARY OF STATE
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on June 19, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☒ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☐ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On August 20 and September 7, 2007, the respondent was operating under and subject to the provisions of the Act.

- On those dates, an employee-employer relationship existed between the petitioner and respondent.

- In the year preceding the injury on August 20, 2007, the petitioner earned $45,685.50; the average weekly wage was $878.57. In the year preceding the injury on September 7, 2007, the petitioner earned $45,856.00; the average weekly wage was $881.85.

- At the time of injuries, the petitioner was 64 years of age, single with no children under 18.

- The parties agreed that the issue of temporary total disability benefits is not in dispute.

ORDER:

- The respondent shall pay the petitioner the sum of $529.11/week for a further period of 15.05 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 7% of her left leg.

- The respondent shall pay the petitioner compensation that has accrued from September 7, 2007, through June 19, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The medical care rendered the petitioner for her left knee was reasonable and necessary. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

- All claims for benefits for her right ankle injury on August 20, 2007, and for her condition of ill-being with her right ankle, shoulders, wrists and lumbar spine are denied and claim #07 WC 44850 is dismissed.

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

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

Robert E. Williams

Signature of Arbitrator

September 4, 2014
Date

SEP 11 2014

FINDINGS OF FACTS:

On August 22, 2007, the petitioner, a computer technician II, sought medical care for right ankle/foot pain and two to three days of swelling at Advocate Health Center. The incident is the subject matter of claim #07 WC 44850. X-rays of her right foot and ankle on August 22nd were negative. A podiatry note by Dr. Reilly on August 23rd indicated a report of foot pain for one month that was unbearable on Monday, the purchase of an ankle brace, burning and the progression of her pain. The doctor recommended immobilization with a CAM walker for right foot tendinitis. On August 24th, the petitioner reported improved right foot pain with the boot.

On September 12th, Dr. Reilly noted the petitioner had been using her Cam walker daily and that she had predominantly left knee pain after slipping on an uneven floor and twisting her leg. The incident is the subject matter of claim #07 WC 44849. On September 21st, the petitioner reported to Dr. Fabros-Munez at Advocate Health Center that she tripped on carpet at work approximately two weeks earlier and hurt her left knee and that she had lower back pain.

On October 12th, Dr. Silver at Illinois Bone and Joint Institute saw the petitioner for her left knee. X-rays that day were normal. On November 1st, Reilly noted that the petitioner reported she had been wearing her boot since August and felt that her ankle pain was much improved. MRIs on November 9th showed mild degenerative arthrosis of her left knee, and an osteochondral injury to the navicular, a calcaneal spur and a small amount of fluid within the posterior joint of her right ankle. On November 19th, Dr. Edward Abraham at Advocate Medical Center saw the petitioner and diagnosed mild osteoarthritis of the left knee. Dr. Silver opined on November 30th that there was damage

to the petitioner's left knee articular cartilage medially and an exacerbation of her pre-existing degenerative condition due to her work injury. Dr. Silver recommended that she undergo arthroscopic surgery. On January 12, 2008, the petitioner received treatment at Advocate Medical Center for foot and bilateral knee pain. On April 28th, the petitioner reported right wrist pain and other problems.

On May 13th, she reported tripping but not falling the day before on the uneven floor at work and having right ankle/foot pain. On May 27th, the petitioner saw Dr. Fleischer at Advocate Medical Center and reported a recent injury to her right foot and ankle on or around May 12th. Dr. Fleischer noted that the petitioner's ankle pain was on the lateral side and did not involve the medial muscle. His diagnosis was a two-week right ankle sprain. X-rays on May 13th showed mild arthritic changes in her right wrist and foot. She reported persistent right ankle pain and discomfort and no significant improvement with use of the ankle stirrup at Advocate on June 14th. An MRI of her right ankle on June 21st showed minor degenerative changes at the talonavicular joint similar to the MRI on November 9, 2007. The petitioner reported improvement on July 8th and no discomfort the past two weeks.

Dr. Fleischer's diagnosis on July 26th was posterior tibial tendinosis with supple rear foot motion and resolved right ankle sprain. The petitioner followed up for her left knee pain on November 17th. X-rays of her left knee on November 21st revealed mild arthritic changes and a small suprapatellar joint effusion. She reported bilateral knee pain, left greater than right, to Dr. Abraham on November 24th. The petitioner followed up with Dr. Fabros-Munez for her left knee on November 28th and reported bilateral shoulder aches on January 29 and February 20, 2009. X-rays of her shoulder on January 29th were

normal. She followed up for her shoulder with Dr. Fabros-Munez on March 20th and reported low back pain on April 6th and May 12th. X-rays of her lumbar spine on April 6th were normal.

The petitioner saw Dr. Fleischman on August 25th for right ankle and foot pain, who noted that he had provided her custom foot orthotics the prior year for posterior tibial tendon dysfunction and recommended adjusting them. Dr. Fleischman's impression on September 22nd was posterior tibial tendinitis in the right ankle, plantar fasciitis in the right heel and gastroc soleal equinus and obesity contributing to the other conditions. He gave the petitioner a steroid injection into her right heel and noted on October 6th that it provided almost complete relief. Pursuant to the petitioner's request, Dr. Fleischman limited her to 30 minutes of standing or walking during an eight-hour workday. An MRI on October 9th revealed mucoid tendinopathy of the posterior tibial tendon medial to the head of the talus and associated thickening of the spring ligaments. On January 13, 2010, the petitioner reported continued discomfort after periods of an hour or more of standing and walking. Dr. Fleischer's impression was Stage 2 posterior tibial tendon dysfunction of the right foot with adult acquired flat foot and mild gastrosoleal equinus. He recommended a Richie type brace, which the petitioner reported improved her symptoms 5%.

FINDING REGARDING THE DATE OF ACCIDENT AND WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner failed to prove that she sustained an accident on August 20, 2007, arising out of and in the course of her employment with the respondent. The medical evidence does not support the

petitioner's testimony of twisting her ankle after tripping on raised flooring at the respondent's place of business. To the contrary, the petitioner reported right ankle/foot pain and two to three days of swelling when she initially sought care at Advocate Health Center, and foot pain for one month that was unbearable on Monday when she sought podiatry care with Dr. Reilly on August 23, 2007. All claims for benefits for her injury on August 20, 2007, are denied.

Based upon the testimony and the evidence submitted, the petitioner proved that she sustained an accident on September 7, 2007, arising out of and in the course of her employment with the respondent. The petitioner reported left knee pain to Dr. Reilly on September 12, 2007, due to slipping on an uneven floor and twisting her left leg. And, on September 21, 2007, she complained of left knee pain to Dr. Fabros-Munez after tripping at work approximately two weeks earlier.

FINDINGS REGARDING WHETHER TIMELY NOTICE WAS GIVEN TO THE RESPONDENT:

The notice date of both of the petitioner's applications for adjustment of claim was October 9, 2007. The respondent received timely notice of the petitioner's injury on September 7, 2007, for claim #07 WC 44849. The respondent did not receive timely notice of the petitioner's injury on August 20, 2007, for claim #07 WC 44850, since her filing was more than 45 days after the injury and she did not prove that the respondent was given any notice of a work injury before the notice of the filing of her claim. All claims for benefits for her injury on August 20, 2007, are denied.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for her left knee was reasonable and necessary. The medical care rendered the petitioner for her right ankle, shoulders, wrists

and lumbar spine was not reasonable or necessary and is denied. The petitioner's group health insurance paid her medical bills for her left knee injury.

FINDING REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that her current condition of ill-being with her left knee is causally related to the work injury. The petitioner failed to prove that her condition of ill-being with her right ankle, shoulders, wrists and lumbar spine is causally related to a work injury. All claims for benefits for her condition of ill-being with her right ankle, shoulders, wrists and lumbar spine injury are denied

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner currently complains of left knee pain for which she uses an elastic band. She had a mild exacerbation of her pre-existing degenerative arthrosis in her left knee. The respondent shall pay the petitioner the sum of $529.11/week for a further period of 15.05 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 7% of her left leg.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Wieslaw Rogalski,

Petitioner,

vs. NO: 10 WC 47231

Rick Trans Co., and ILLINOIS STATE TREASURER as ex officio custodian of THE INJURED WORKERS ' BENEFIT FUND,

15IWCC0664

Respondents,

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Illinois State Treasurer as ex officio custodian of the Injured Workers' Benefit Fund herein and notice given to all parties, the Commission, after considering the issues of temporary total disability and permanent disability and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Petitioner is entitled to temporary total disability from March 26, 2010 through April 13, 2010 or 2 4/7 weeks. Petitioner is also entitled to permanency in the amount of 5% loss of use of the person as a whole.

All medical bills pertaining to Petitioner's back shall be paid by Respondent through April 13, 2010. All medical bills after that date are the responsibility of the Petitioner.

The Petitioner received treatment for his injury on March 26, 2010 through April 13, 2010. He did not receive another treatment or see another physician until after an unrelated accident which occurred on October 15, 2010. (Transcript Pgs. 44-45) The Petitioner testified that the only restriction he was placed under was by the physician who saw him after the second accident. That restriction was no lifting over 25 pounds. (Transcript Pg. 53) The Commission therefore finds that Petitioner is entitled to receive temporary total disability from March 26, 10210 through April 13, 2010 the last date he received treatment for this injury.

The Petitioner testified that he is still an interstate truck driver and that he hauls the same things that he did for the Respondent. An MRI taken of the Petitioner's cervical spine on April 2, 2010 revealed a 4mm right central intervertebral disc extrusion at C6-7. There was also an annular bulging of 2mm at C4-5. Although it was not introduced into evidence, it appears that the Petitioner had another MRI to his cervical spine on November 8, 2010 after the Petitioner's unrelated accident. (Petitioner Exhibit 11) The Petitioner testified that as a result of the March 6, 2010 accident he constantly has pain in his neck and shoulder. Sometimes the pain is so great he cannot hold a cup of coffee. (Transcript Pgs. 44-45) However, no restrictions were placed on the Petitioner until his second unrelated accident. The Commission therefore finds that Petitioner is entitled to 5% loss of use of a person as a whole.

The Petitioner stopped receiving treatment as a result of his March 6, 2010 injury on April 13, 2010. He did not receive any further treatment until he had his unrelated accident on October 15, 2010. The Commission finds that the Illinois Workers' Benefit Fund is only liable to pay for the medical bills incurred until April 13, 2010.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $423.02 per week for a period of 2 4/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $380.72 per week for a period of 25 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use to the person as a whole.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the related medical expenses through April 13, 2010 under §8(a) of the Act and §8-2.

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.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured

15IWCC0664

Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $10,800.00. 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.

DATED: AUG 25 2015

Charles J. DeVriendt

Joshua D. Luskin

Ruth W. White

HSF
O: 7/14/15
049

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROGALSKI, WIESLAW
Employee/Petitioner

Case# **10WC047231**

RICK TRANS CO AND STATE TREASURER AS EX OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

15IWCC0664

On 9/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2053 LAW OFFICE OF GEORGE L TAMVAKIS
53 W JACKSON BLVD
SUITE 601
CHICAGO, IL 60604

RICK TRANS CO
4039 N ORIOLE
NORRIDGE, IL 60706

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0664

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

Wieslaw Rogalski
Employee/Petitioner

v.

Rick Trans Co. and
State Treasurer as ex officio Custodian of the Injured Workers' Benefit Fund
Employer/Respondent

Case # **10** WC **47231**

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 **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **May 29, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **March 6, 2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$31.904.31**; the average weekly wage was **$634.53**.

On the date of accident, Petitioner was **50** years of age, ***single*** 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** 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 **$423.02**/week for **28 6/7^{ths}** weeks, commencing **March 26, 2010**through **October 15, 2010** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **March 26, 2010** through **May 29, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of **$27,126.24** as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$380.72**/week for **50** weeks, because the injuries sustained caused the **10%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

September 5, 2014
Date

SEP 5 - 2014

STATEMENT OF FACTS

Petitioner, Wieslaw Rogalski, testified that on March 6, 2010, he was employed as a truck driver for Respondent, Rick Trans. Co., and had been so employed by Respondent for the previous two years. Petitioner testified that the owner of Rick Trans. Co. was Richard Kobierski, and that the company was located at 501 Tuscany Drive, Algonquin, Illinois. Petitioner testified that his job as a truck driver was to transport goods from the Chicago area to other out of state destinations such as Florida, Arizona and Oregon. Once he arrived at the destination and the goods were unloaded, he would drive to another location, reload, and transport the goods back to the Chicago area. Petitioner testified that he drove two of Respondent's 18 wheeler trucks, a Volvo and a Freightliner. Initially Petitioner drove the Volvo truck, but further on in his employment, he solely drove the Freightliner. Petitioner testified that Respondent owned the trucks and that Respondent's name and ICC number were painted on the sides of the trucks. Petitioner testified Respondent was responsible for all the maintenance and repairs to the trucks. Petitioner identified Petitioner's Exhibit 4 (PX4), as a photograph of three trucks owned by Respondent, which included the Volvo and Freightliner that he drove. Petitioner marked the Freightliner in PX4 to distinguish it from the Volvo and the other truck. Petitioner identified Petitioner's Exhibits 5 and 6 (PX5 and PX6) as close up photos of the Freightliner truck that he drove. Petitioner testified that photos in PX4, PX5 and PX6 clearly depict Respondent's name and ICC number painted on the sides of the trucks.

Petitioner testified Mr. Kobierski gave him all of his assignments, instructed him where to go and what to pick up, pursuant to a time schedule. When Petitioner had to fill the truck with gas, he would call Mr. Kobierski who would supply him with a code number. Petitioner would give this code number to the gas attendant to pay for the gas. Petitioner testified that Mr. Kobierski would give him several documents including a logbook, the bill of lading and "so forth" for each round trip and return them to Mr. Kobierski after the trip. Petitioner testified that Respondent's name was on the bill of lading.

Petitioner testified that he was paid per trip. He testified that he and Mr. Kobierski would agree on a set fee. For example, Petitioner testified that he was paid $1,100 round trip to Florida and $1,140 to Phoenix,

Arizona. He testified that Mr. Kobierski would agree to pay him a little more if he had to wait over four hours or had to drive over 300 miles to reload before returning to Chicago,. Petitioner testified he was paid by check. Petitioner identified Petitioner's Exhibit 7 (PX7), as copies of the checks he received as payment from Respondent for the year preceding March 6, 2010. Petitioner testified that each of the checks contain Respondent's name. Petitioner testified that the first 20 copies were made directly payable to him. Petitioner testified that the remaining checks in PX7, beginning with the check dated December 7, 2009, are made payable to Quality Maid. Petitioner testified that in December, 2009, Mr. Kobierski ordered him to set up a company. Petitioner testified that Mr. Kobierski told him that did not want to pay him directly any longer. Petitioner testified that Mr. Kobierski stated if he did not comply with the order, he would terminate him. Petitioner testified that he paid some money and set up a company called Quality Maid. Petitioner testified that he never used Quality Maid for any business, and never used it for any purpose other than to receive checks from his employment with Respondent.

Petitioner testified that on March 6, 2010, he was driving the Freightliner to Phoenix, Arizona, when he stopped to check the oil. Petitioner testified that he could not open the hood easily, but was finally able to do so using a lot of force. Petitioner testified that he later realized that the springs were broken. As Petitioner was closing the hood, the hood went down fast and Petitioner held on to it with his right arm to stop the hood from crashing. Petitioner stated that the hood was extremely large and heavy, and that it forcefully pulled his arm down as it was closing. Petitioner immediately felt a "pushing" pain in his neck, back and top of the right shoulder. Petitioner testified he tried to stretch and control the pain. When the pain did not decrease, Petitioner called Respondent, explained the accident, and informed him that he had hurt his neck, right shoulder, and arm. Petitioner testified that Respondent replied something to the effect of, "it does not matter – go on." Petitioner testified that after the accident, he had great difficulty using his right arm to shift the gears. He testified that there is a bar inside the truck to help lift himself up from the sleeping cabin, but that he could not lift his arm to use it the next morning. Petitioner testified that the next day, he could not lift the hood, but that he was able to see that springs were broken and that the belt was "laying there." Petitioner testified that he again called Respondent and told him about the broken springs of the truck and his current painful condition. Respondent replied "no matter" and instructed him to "go on" and deliver the goods and bring the truck back. Petitioner did as Respondent ordered and returned the Freightliner.

Petitioner testified that his condition did not improve after the accident and that on March 26, 2010 Petitioner went to emergency room at Resurrection Hospital. He testified that he was supposed to visit his sister that day, but he felt dizzy, and felt sharp pain in his neck, right shoulder, arm and hand. Petitioner testified that he had a heart attack 10 years ago, and was worried that the March 6, 2010 accident was causing him to have

another one. Petitioner testified that he told the hospital doctors about his accident on March 6, 2010, and described the pain in his neck and right shoulder, as well as pain radiating down his right arm. Petitioner also told them that he was experiencing chest pain. Petitioner testified that he had a series of heart tests at the hospital and that the results were normal.

Petitioner testified that on April 1, 2010, he sought additional medical treatment at Herron Clinic located at Division and State. He testified that he informed the doctor at the clinic of the March 6, 2010 accident and resulting injury of neck pain, right shoulder pain, right elbow pain and numbness and tingling radiating to his right arm and right hand. Petitioner testified that he was referred for an MRI of his cervical spine and right shoulder. Petitioner testified that he subsequently had physical therapy. He testified that he was referred for pain management and that the pain specialist prescribed injections. Petitioner testified that he never followed up with the injections or any other further medical treatment because he had no insurance.

Petitioner testified that when he was released from Resurrection Hospital, he gave the hospital off work medical note to the Respondent. Petitioner testified that Mr. Kobierski stated something to the effect of "what do you want me to do about it?" Mr. Kobierski then told Petitioner to get out. Petitioner testified that since he was admitted to Resurrection Hospital on March 26, 2010, he never worked for Respondent again. Petitioner testified he had a non-work related accident on October 15, 2010.

Petitioner testified that he still has constant pain in his neck, right shoulder and right arm caused by his accident on March 6, 2010. He testified that sometimes the pain is so significant that he cannot sleep.He testified that he sometimes cannot hold a cup a coffee. He testified that the weather can affect the level of his pain. He testified that he is right hand dominant. He testified that he currently drives a truck to transport goods, and that he now uses automatic shift. He testified he requested a truck with an automatic shift from his current employer because he can no longer drive a truck with a manual shift due to his injuries.He testified that he can no longer unload goods from his truck and cannot do any type of maintenance to the truck. Petitioner testified that prior to the accident on March 6, 2010 he had no pain to his back, neck, right shoulder, right arm or hand.

Petitioner testified that on March 6, 2010, he was 50 years old, married, and had one child under the age of 18.

The medical records indicate that Petitioner was admitted to the emergency room at Resurrection Hospital on March 26, 2010 for chest pain, back pain and right shoulder and arm pain. PX8. Petitioner complained of severe pain. PX8, p. 19. Petitioner informed the physicians about the accident and his current condition: "PT states 3 weeks ago, I changed oil in my big truck, I[sic] pulled fast then next day I have the pain. Per PT states pain to right chest is 7/10 and back pain 8/10. +L ROM to right arm." PX 8, p. 18.

A series of heart tests were performed on Petitioner with normal results. PX8 pp.112, 125.

The medical records indicate that on April 1, 2010 Petitioner sought medical treatment at Herron Medical Center and was examined by a Dr. Bermudez. PX10. Petitioner described his neck pain, right shoulder pain, right elbow pain and numbness and tingling radiating to his right arm and hand. PX10, p.4.

The medical records indicate that Petitioner underwent an MRI of his cervical spine and an MRI of his right shoulder that same day. The findings of the cervical MRI were a 4 mm, right central intervertebral disc extrusion at C5-C6, leading to posterior displacement and compression of the cervical spinal cord; and a 2 mm diffuse annual bulge at C4-C5. PX10, p. 6.

On April 13, 2010, Petitioner was referred to Dr. Harsoor for evaluation and management of his neck pain. PX12 Dr. Harsoor prescribed a series of epidural injections and trigger point injections and noted that they were to be scheduled. PX12, p.5

Petitioner admitted into evidence proof that Respondent, Rick Trans. Co, did not have insurance at the time of Petitioner's injury and that the owner of Rick Trans. Co. was Richard Kobierski. (PX1 and PX2). Petitioner admitted into evidence the letter and proof of certified mail to Richard Koberski (PX3), and an Affidavit of Service for Richard Kobierski (PX14). Petitioner admitted into evidence the medical bills for Resurrection Hospital (PX9), Herron/Alivio Medical Center (PX11), and Illinois Pain Management medical bill (PX13), and medical bill summary (PX15).

CONCLUSIONS OF LAW

In support of (A), Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupation Diseases Act?

Petitioner testified that he worked as an interstate truck driver.

Therefore, the Arbitrator finds that Rick Trans was operating under and subject to the Act

In support of (B), Was there an employee-employer relationship?

Respondent hired Petitioner to transport goods using the trucks Respondent owned and maintained. The trucks have Respondent's name and ICC number painted on the sides. At all times Respondent maintained supervising control. Respondent gave Petitioner all of his assignments and instructed him where to go and what to pick up pursuant to a time schedule. When Petitioner had to fill the truck with gas, he was required to contact Respondent to obtain authority and monetary payment. Petitioner was required to use a logbook, have a bill of lading for each trip, and return them to Respondent. Respondent's name was on the bill of lading. Respondent paid Petitioner by check bearing Respondent's name

Therefore, the Arbitrator finds that an employer-employee relationship did exist.

In support of (C), did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?

The Arbitrator finds that the accident on March 6, 2010, occurred out of and in the course of Petitioner's employment with Respondent. Petitioner was injured while closing the hood of Respondent's Freightliner truck after he changed the oil. This accident occurred when Petitioner was en route to Phoenix, Arizona, transporting goods under Respondent's orders, direction, and control.

In support of (D), what was the date of accident?

Based on the testimonial and documentary evidence, the Arbitrator finds that the date of accident was March 6, 2010.

In support of (E), was timely notice of the accident given to Respondent?

The Arbitrator finds that Respondent received notice of the accident on the date of the occurrence. Petitioner testified that on March 6, 2010, he called Mr. Kobierski to inform him of his accident.

In support of (F), is Petitioner's current condition of ill-being causally related to the injury?

Petitioner testified that he had never experienced pain in his neck or shoulder prior to March 6, 2010 nor do any of the medical records indicate any prior problems.

The Arbitrator finds that based on Petitioner's testimony that he began to experience pain in his neck and right shoulder immediately upon attempting to keep the hood of the truck open, his current complaints as they relate to his neck and shoulder are related.

The Arbitrator further finds that any cardiac complaints regarding Petitioner's chest pain are not related.

In support of (G), what were Petitioner's earnings?

The Arbitrator finds that Petitioner's average weekly wage for the year preceding his injury is $634.53.

This finding is based upon Petitioner's checks from Respondent (PX7).

In support of (H), what was Petitioner's age at the time of the accident?

Based upon the medical records of Resurrection Hospital (PX8), and Petitioner's testimony, the Arbitrator finds that Petitioner's date of birth is July 19, 1959, and that Petitioner was 50 years old at the time of the accident on March 6, 2010.

In support of (I), what was Petitioner's marital status at the time of the accident?

Based upon Petitioner's testimony, the Arbitrator finds that Petitioner was not married at the time of the accident on March 6, 2010.

In support of (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 the medical services provided to the Petitioner were reasonable and necessary. The Arbitrator finds that Respondent did not pay for any of the reasonable and necessary medical services. The Arbitrator further finds that the following medical bills which total $27, 126.24, are due and owing pursuant to the fee schedule:

1. Resurrection Hospital:	$17,831.00
2. Herron/Alivio Medical Center medical bills:	$250.15
3. Lakeshore Open MRI:	$8,380.09
4. Illinois Pain Management:	$665.00

In support of (K), What temporary benefits are in dispute,

The Arbitrator finds that Petitioner is entitled to the claimed temporary total disability benefits of 28 6/7 weeks from March 26, 2010 to October 15, 2010.

Petitioner testified that he was off from work for his injuries and that he submitted the hospital off work medical note to the Respondent, who was dismissive. The medical records corroborate that Petitioner was to remain off work.

In support of (L), What is the nature and extent of the injury?

Based upon the testimonial and documentary evidence, the Arbitrator finds that Petitioner sustained the 10% loss of the person as a whole.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

BRAD BUSCH,

Petitioner,

vs. NO: 13 WC 31876

IL DEPT. OF TRANSPORTATION,

Respondent,

15IWCC0665

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issue of nature and extent, 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 finds that Petitioner only sustained permanent partial disability to the extent of 3% loss of use of the left foot. Regarding the fifth factor in Section 8.1b of the Act, we find that Petitioner's testimony related to his current disability is not corroborated by the medical records. Petitioner testified that he limps on the left side, his ankle feels weak and stiff, and he has throbbing pain, and can't stand for long periods. However, the last medical record of Dr. Eavenson, on October 30, 2013, does not support this testimony because it indicates that Petitioner was "doing great" and had no swelling, full range of motion, and no weakness. Petitioner did not return to his physicians to complain about any of these current problems but, on redirect, he testified that this record was from before he returned to work and that with the increased activity for the past year his symptoms have worsened. Nevertheless, Petitioner's current testimony and evidence of disability is not corroborated by the medical records. Therefore, we reduce the permanent partial disability award to 3% loss of use of the left foot.

All else is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to

15IWCC0665

Petitioner the sum of $692.51 per week for a period of 5.01 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of use of 3% of the left foot.

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

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

DATED: AUG 25 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 8/11/15
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BUSCH, BRAD
Employee/Petitioner

Case# **13WC031876**

IL DEPT OF TRANSPORTATION
Employer/Respondent

15IWCC0665

On 2/11/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.08% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1053 JOSEPH L SAMUELSON PC
5111 W MAIN ST
BELLEVILLE, IL 62226

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

3291 ASSISTANT ATTORNEY GENERAL
DIANA E WISE
201 W POINTE DR SUITE 7
SWANSEA, IL 62226

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

1430 CENTAL MGMGT SERVICES
WORKERS' COMPENSATION CLAIMS
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

FEB 11 2015

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

15IWCC0665

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

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Brad Busch
Employee/Petitioner

v.

Illinois Department of Transportation
Employer/Respondent

Case # 13 WC 31876

Consolidated cases:

The only disputed issue is the nature and extent of the injury. An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Edwards Lee**, Arbitrator of the Commission, in the city of **Collinsville**, on **December 17, 2014**. By stipulation, the parties agree:

On the date of accident, **September 6, 2013**, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $**60,017.53**, and the average weekly wage was $**1,154.18**.

At the time of injury, Petitioner was **48** years of age, with **-2-** dependent children.

Necessary medical services and temporary compensation benefits have been provided by Respondent. — See "A" attached and made a part hereof.

Respondent shall be given a credit of $**5,064.72** for TTD, $ **-0-** for TPD, $ **-0-** for maintenance, and $ **-0-** for other benefits, for a total credit of $**5,064.72**.

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

ORDER

Respondent shall pay Petitioner the sum of $ **692.51** for a further period of 12.525 weeks, as provided in Section **8(e)(11)** of the Act, because the injuries sustained caused **loss of use of the left foot to the extent of 7.5% thereof. --- See "A" attached and made a part hereof.**

Respondent shall pay Petitioner compensation that has accrued from **October 6, 2013** through **December 17, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

2/9/15
Date

FEB 11 2015

Re: **Brad Busch v. IDOT**
13-WC-31876

15IWCC0665

"A"

The Arbitrator hereby makes the following Finding of Facts:

Petitioner is employed by Respondent within its highway maintenance program. On September 6, 2013, he sustained accidental injuries, arising out of and in the course of his employment. He injured his left ankle and foot stepping into a hidden hole on the side of Highway 157. (Pet. Ex. #1) He immediately experienced a popping sensation with pain throughout the ankle joint. Despite this discomfort, Petitioner attempted to continue working. However, his left foot began to swell and became numb. He reported his worsening condition to Respondent and, as a result, was driven to Anderson Hospital. He was treated in the emergency room with x-rays, pain medication and a walking boot. He was further instructed to seek additional care with his primary care physician. (Pet. Ex. #2)

After an examination by his family doctor, he was referred to Drs. Eavenson and Lupardis, (d/b/a Multi-Care Specialists) for orthopedic treatment. Upon initial consultation, Dr. Lupardis noted ecchymosis over the lateral aspect with marked tenderness along the anterior lateral aspect of the left ankle. Inversion of the foot caused pain and there was laxity upon range of motion testing. Dr. Lupardis felt petitioner had "likely received significant injury to the ligaments." His initial diagnosis was left ankle sprain/strain with an ATF tear and a possible tear of the peroneus brevis. He placed Petitioner in a Cam Walker, kept him off work and prescribed an MRI scan. (Pet. Ex. #4)

Done on September 13, 2013, the MRI scan revealed peroneus tenosynovitis/tendonitis without a tear and a grade 1 sprain of the anterior telofibular ligament. (Pet. Ex. #3) Based upon these results, Petitioner's physicians instituted a regimen of rehabilitative therapy. This lasted until October 30, 2013. During this period Petitioner wore the Cam Walker and received regular treatments at MultiCare. (Pet. Ex. #4) At that time, Petitioner's condition had improved to the point he was released to return to work on November 4, 2013. In all, Petitioner lost 6 3/7 weeks of work during which he received temporary total disability benefits.

In seeking the abovesaid care and treatment for his injuries, Petitioner incurred various medical expenses as outlined in Petitioner's Exhibit #5 and various payments have been made as outlined in Respondent's Exhibit #4. The parties have stipulated Respondent shall be responsible (pursuant to the Medical Fee Schedule) for payment of all reasonable and necessary medical expenses incurred by Petitioner from September 6, 2013 through October 30, 2013. It shall also receive credit for all payments made prior to December 17, 2014 (date of this hearing). Further, if any payments were mistakenly made by Petitioner's group insurance carrier, Respondent shall receive credit pursuant to the terms of Section 8(j) and in consideration thereof shall hold Petitioner harmless from any and all claims for reimbursement or repayment of same.

Since returning to work, Petitioner has continued to suffer the effects of his injury. Specifically, he testified to the following:

1) Persistent pain and discomfort on the lateral aspect of the left ankle.
2) A decrease of extension and flexion of the ankle.
3) Weakness of the ankle causing him to favor his right foot.
4) Difficulty standing for long periods or walking for extended distances.

Based upon the foregoing facts, the Arbitrator makes the following conclusions:

As a result of this undisputed accident, the Petitioner has suffered serious and permanent injuries to the extent of 7.5% loss of use of the left foot pursuant to Section 8(e)(11). In making this determination of permanent partial disability, the Arbitrator looks to the five factors as set forth in Section 8.1b of the Act which are: 1) an AMA impairment rating, 2) Petitioner's occupation, 3) Petitioner's age at the time of the injury, 4) Petitioner's future earning capacity, and 5) evidence of disability corroborated by the medical records. In applying this criteria to the present case, the Arbitrator notes the following:

1. Neither party submitted a numerical level of impairment calculated pursuant to AMA guidelines.

2. Petitioner is employed by Respondent as a member of its highway maintenance program. This requires the performance of manual labor, including standing for extended periods and walking on uneven terrain. As a result of his injuries, Petitioner continues to experience pain and discomfort in his left ankle/foot when performing these duties.

3. Petitioner is currently 49 years of age. He has a long work life ahead of him. The effects of his injury will continue to hinder him for the foreseeable future.

4. Despite the persistent nature of his injury, there is no evidence of an adverse effect upon his future earning capacity.

5. Petitioner's evidence of disability is demonstrated by the medical evidence herein. The nature of petitioner's injuries are clearly delineated with the medical records and further corroborated by his credible testimony.

STATE OF ILLINOIS)
) SS.
COUNTY OF ROCK ISLAND)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMIE BURDICK,

Petitioner,

vs.

NO: 12 WC 28966

CAMTEK, INC.,

15IWCC0666

Respondent,

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent and Petitioner herein and notice given to all parties, the Commission, after considering the issues of causation, temporary total disability, medical, and wage/benefit rates, 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 finds that Petitioner failed to prove that her currently alleged low back and leg conditions of ill-being are causally related to her work injury on December 15, 2011. We find Petitioner's testimony to be inconsistent and not credible and we find the opinion of Respondent's Section 12 examiner, Dr. Van Fleet, to be most persuasive on the issue of causation.

Petitioner testified that she continued to work full duty after the accident on December 15, 2011, and when she was laid off by Respondent on November 8, 2012, she obtained work through a temporary service. (T.11, 14, 20). On cross-examination, Petitioner admitted that she requested a full duty work note from Dr. Li on September 17, 2013. (T.21). Dr. Li's records indicate that this work release was provided because she was going to work through Abby Placement Services. (Px15).

Petitioner testified that she continued working until October 30, 2013 when Dr. Li took her off work because her "pain was getting worse." (T.21-22). However, upon further questioning, Petitioner admitted that she actually had stopped working around October 1, 2013 because the

employer had no more work for her. It was after this that she returned to Dr. Li on October 30th and was taken off work completely. (T.22-23, Px15).

We also note that Petitioner then testified that she had continued to look for work until October 30th but then stopped looking because her pain was getting worse. (T.24). However, she then admitted that she had been receiving $254.00 in unemployment compensation from December 2012 through May 2014 and testified that she was looking for work the "entire time." (Id.) The Commission finds that Petitioner's testimony is inconsistent and not credible regarding her symptoms, the reasons she was taken off work, and her inability to perform full duty work.

Dr. Van Fleet examined Petitioner and reviewed medical records on April 5, 2013. He testified about inconsistencies in her ability to walk without any evidence of a footdrop but yet Petitioner was unable to heel or toe walk. He also noted that Petitioner had give-way weakness to manual motor testing, which is not consistent with true motor strength. He opined that Petitioner had reached maximum medical improvement from her work injury. He did not believe Petitioner required any further formal treatment, studies, or referrals to a neurosurgeon but that she would benefit from weight reduction and exercise. He did not find any indication of permanent impairment and did not believe she needed any work restrictions.

Based on our determination of Petitioner's credibility and Dr. Van Fleet's persuasive opinion, we find that Petitioner's condition of ill-being was no longer causally related to her work injury as of April 5, 2013. All awards for temporary total disability, medical expenses, and prospective medical are vacated.

All else, including the Arbitrator's determination of average weekly wage, is affirmed and adopted.

IT IS THEREFORE ORDERED BY THE COMMISSION that the awards for temporary total disability, medical expenses, and prospective medical are hereby vacated.

IT IS FURTHER ORDERED BY THE COMMISSION that this case be remanded to the Arbitrator for further proceedings consistent with this Decision, but only after the latter of expiration of the time for filing a written request for Summons to the Circuit Court has expired without the filing of such a written request, or after the time of completion of any judicial proceedings, if such a written request has been filed.

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

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

DATED: AUG 2 5 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 8/4/15
49

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

BURDICK, JAMIE
Employee/Petitioner

Case# **12WC028966**

CAMTEK INC
Employer/Respondent

15IWCC0666

On 8/25/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0564 WILLIAMS & SWEE LTD
JEAN SWEE
2011 FOX CREEK RD
BLOOMINGTON, IL 61701

2871 LAW OFFICES OF PATRICIA M CARAGHER
MARY FLANAGAN-DEAN ESQ
1010 MARKET ST SUITE 1510
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF Rock Island)

☐ 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)

Jamie Burdick
Employee/Petitioner

v.

Camtek, Inc.
Employer/Respondent

Case # 12 WC 28966

Consolidated cases: _____

15IWCC0666

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 **Gregory Dollison**, Arbitrator of the Commission, in the city of **Rock Island, Illinois**, on **July 2, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0666

On the date of accident, **12-15-11**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**12,637.65**; the average weekly wage was $**382.96**.

On the date of accident, Petitioner was **35** years of age, ***single*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $255.30/week for 34 6/7 weeks, commencing 10-30-13 through 7-2-14, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $272 to Applied Pain Institute, and $110 to McLean County Neurology, as provided in Sections 8(a) and 8.2 of the Act.

Respondent to authorize the MRI, neurosurgical evaluation, and follow up treatment as recommended.

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

8/22/14
Date

ICArbDec19(b)

AUG 25 2014

FINDINGS OF FACT

On December 15, 2011, Petitioner, a 35 year old, worked for Respondent making agricultural and military circuit boards for agricultural and military. On that date, Petitioner slipped on some grease on the floor and fell landing on her buttocks with her feet straight out in front of her. After she fell, Petitioner experienced immediate low back and leg pain.

Petitioner informed her supervisor, "Tony," about her accident and filled out an accident form. Petitioner testified she continued to work, but noticed increasing stiffness in her low back and leg pain.

Petitioner testified that pursuant to the recommendation of "Tony" she began treating with Dr. Chow, an occupational medicine doctor at OSF Occupational Health. Petitioner presented to Dr. Chow on December 29, 2011. Dr. Chow recorded a history of accident consistent with Petitioner's testimony. Dr. Chow noted that Petitioner had back pain, bilateral leg pain, and leg weakness with aching since her work accident on December 15, 2011. Dr. Chow's provider notes indicate that Petitioner had muscle spasms. Upon exam, Dr. Chow noted that Petitioner could not walk on her heels and toes on the right side and that she had difficulties with heel and toe walking on her left side. Dr. Chow also noted Petitioner had left foot weakness and had trouble ambulating since the accident. Dr. Chow assessed low back pain with difficult left foot ambulation (weakness). A MRI was ordered and Dr. Chow returned Petitioner to work without restrictions. (PX 2)

Petitioner underwent the prescribed MRI on January 13, 2012. The radiologist, Dr. Yousuf, noted the MRI demonstrated Petitioner had mild degenerative disc disease at L4-5 and L5-S1 with a tiny central disc herniation at L4-5 with associated facet disease and an annular tear of the disc at that level. The radiologist stated that there was a lateral recess stenosis which may translate into some degree of L5 symptoms. (PX 3)

Petitioner returned to Dr. Chow on January 17, 2012. Dr. Chow noted Petitioner still had low back pain when going from a sitting to standing position and that her legs still ache. Dr. Chow recorded that Petitioner had shooting pain into her legs, with more pain in the right leg. Dr. Chow also noted Petitioner had surges of pain in her left leg into her toes and that her legs felt heavy. Upon exam, Dr. Chow noted Petitioner had tenderness in her low back. Dr. Chow's diagnosis was low back pain associated with bilateral leg pain. Dr. Chow prescribed Prednisone and referred Petitioner to a neurologist. Petitioner work status remained the same. (PX 18)

Pursuant to Dr. Chow's referral, Petitioner saw Dr. Pegg, a neurologist, on January 25, 2012. Dr. Pegg took a history of accident consistent with Petitioner's testimony. Dr. Pegg recorded Petitioner's complaints that she currently felt a hot sensation in her lower back on the left side and that she sometimes noticed pain shooting out of the fifth toe of both feet. Upon exam, Dr. Pegg noted Petitioner had a reduced tone in her right ankle which he could not explain. Petitioner's right ankle tone was hypotonic. Dr. Pegg indicated Petitioner's ankle jerks were surprisingly absent bilaterally and that she had good range of motion in her back. Dr. Pegg stated that Petitioner was unable to walk on her heels due to an inability to dorsiflex her foot and she had a functional component to her exam. The doctor also referenced that the MRI previously taken showed a bulge at L4-5 with no other significant changes. Dr. Pegg concluded that Petitioner had a fall on December 15, 2011 and had persistent and unremitting symptoms since that time. Dr. Pegg stated that these symptoms were not classic for radiculopathy and that he did not find anything that clearly fit with a lumbosacral radiculopathy. Dr. Pegg opted not to undergo an EMG at that time. He stated Petitioner had a soft tissue injury that should respond to

conservative management. Dr. Pegg ordered a muscle relaxant and anti-inflammatory medication. He noted the possibility that injections may be necessary if these medications are not sufficient. (PX 18)

Petitioner testified that her low back and bilateral leg pain continued to progress and worsen.

Records submitted show that in March of 2012, Petitioner reported that she was standing up from a seated position and noticed left knee pain. As a result, Petitioner saw Dr. Seidl, an orthopedic surgeon, on March 20, 2012. Dr. Seidl ordered an MRI of Petitioner's left knee which revealed a medial meniscus tear. Petitioner underwent a partial lateral meniscectomy on April 11, 2012. Petitioner made an uneventful recovery. (PX 29) Petitioner testified and Dr. Seidl's records reflect that she did not re-injure her back in March, 2012. (PX 29)

Petitioner testified that she continued with ongoing back pain. She saw her her family doctor, Dr. Djagarian, on March 30, 2012. Records show she described bilateral leg swelling and pain for almost two (2) months. Petitioner informed Dr. Djagarian she also had left knee pain. (PX 19)

Petitioner treated with Dr. Djagarian on April 13, 2012 and May 24, 2012. On May 24th, Petitioner reported progressively worsening low back pain. Dr. Djagarian recorded that Petitioner provided that her back pain started since December 2011 and that same was worse on the left side. Dr. Djagarian assessed lower back pain and lumbar radiculopathy. Physical therapy was ordered. (PX 19)

On June 1, 2012, Petitioner commenced physical therapy at Advocate Bromenn Physical Therapy Services. On said date, the physical therapist, Katrina Hind, PT, DPT, noted that Petitioner fell at work in December of 2011 and that she has had worsening back and lower leg pain with foot weakness. Upon exam, the therapist noted Petitioner had mild loss of lumbar range of motion, diminished sensation in the right foot, and myotomal weakness in L5 and S1. The therapist stated that Petitioner's prognosis was guarded. (PX 4)

Petitioner followed with Dr. Djagarian regarding her low back pain on July 5, 2012. The doctor continued to assess lower back pain and lumbar radiculopathy. Petitioner was referred to a neurologist at that time. (PX 19)

Therapy notes show Petitioner was again seen on July 18, 2012. The therapist, Trina Glenn, noted that Petitioner's left foot and toes were getting progressively worse in terms of sensory loss and proprioception. The therapist stated that Petitioner has had an apparent progressive neuropathy of both legs, that her ankle inversion was 4+/5, bilateral eversion was 4/5 on the right and 4+/5 on the left, dorsiflexion was 2/5 bilaterally, plantar flexion was 2/5 bilaterally, and that Petitioner's left gastric was significantly larger than the right. (PX 8)

Consistent with Dr. Djagarian referral, Petitioner saw Dr. Hayden, a neurologist, on July 20, 2012. Dr. Hayden noted a history of accident consistent with Petitioner's testimony. Dr. Hayden stated that Petitioner's low back and leg weakness had been progressing over the last 6 to 7 months after her fall at work. On exam, Petitioner showed decreased pinprick sensation over her left leg. Dr. Hayden noted that Petitioner's lumbar MRI film showed a disk bulge at L4-5 with no evidence of severe central or lateral recess stenosis that would necessitate neurosurgical intervention. Dr. Hayden ordered an EMG/NCV of both lower extremities to rule out peripheral neuropathy or lumbar radiculopathy. He also ordered arterial doppler of the lower extremities to rule out vascular insufficiency. (PX 5) The arterial doppler was normal.

Petitioner underwent the EMG on August 22, 2012. Dr. Hayden provided that the EMG showed a mild bilateral L5 radiculopathy with increased insertional activity in the peroneus longus and lower lumbar paraspinals. Dr. Hayden stated that he was optimistic that Petitioner's condition might be managed conservatively without surgery and referred Petitioner to Dr. Ji Li for a trial of epidural steroid injections. (PX 6)

Petitioner presented to Dr. Li on August 29, 2012. Dr. Li noted a history of accident consistent with Petitioner's testimony. Dr. Li noted Petitioner had low back pain with radiating pain to the left buttock and pain in both legs. Dr. Li noted that Petitioner was still working, however she had increased pain with prolonged standing and walking. Dr. Li also noted that Petitioner did not have back pain until her work accident. Dr. Li recommended bilateral L4-S1 transforaminal epidural steroid injections with the possibility of future lumbar facet injections. (PX 7)

On September 14, 2012, Petitioner underwent a bilateral L4-5 and L5-S1 ESI. She reported a 50% overall improvement on September 25, 2012. On September 28, 2012, Petitioner underwent a bilateral L4-5 and L5-S1 facet injection. On October 10, 2012, Dr. Li noted overall improvement after the injection treatment. The doctor noted that she was complaining of some stiffness in her neck. Dr. Li assessed lumbar disc disease, left radiculopathy, cervical disc disease, cervical neuralgia, and myofascial pain. Dr. Li ordered physical therapy and prescription medication, Soma. (PX 13)

Petitioner returned to Dr. Hayden on October 22, 2012. On exam, Dr. Hayden noted Petitioner had decreased pinprick sensation stocking distribution to the knees, more densely noted on the right than the left. Dr. Hayden stated that Petitioner had 2+ reflexes on the knees, which were symmetric, and absent in the ankles. Dr. Hayden assessed mild bilateral L5 radiculopathy probably related to the lateral recess stenosis at L4-5. Dr. Hayden recommended that Petitioner continue to follow with Dr. Li. The doctor also indicated he would order a lumbar myelogram and post myelogram CT if Petitioner failed to respond to physical therapy. (PX 10)

Petitioner returned to Advocate Bromenn Physical Therapy Services on November 20, 2012. The therapist, Ms. Hind, reevaluated Petitioner. The therapist stated that Petitioner had some improvement in her back range of motion with therapy, however she had prominent weakness in her legs. The therapist noted Petitioner had prominent foot slap and intermittent curling of her right toes when she tried to initiate a toe push off. The therapist noted that Petitioner had trouble sleeping through the night because of her back pain. (PX 9)

Petitioner returned to Dr. Li on November 21, 2012. Dr. Li noted that Petitioner had finished physical therapy with some improvement. Dr. Li noted Petitioner had constant dull ache to mid low back with no radiculopathy into the legs. The doctor also stated that Petitioner wore a back brace for comfort and that she has no feeling in her right leg since the accident. Dr. Li prescribed acupuncture, Percocet, and Soma. (PX 13)

On February 4, 2013, Dr. Hayden evaluated Petitioner. Dr. Hayden stated that Petitioner should continue using her ankle-foot orthosis for mild foot drop bilaterally, that she should continue with Dr. Li for pain management including Percocet and Soma, that Petitioner should take Cymbalta 60 mg because of low back indication, and that she should undergo a lumbar myelogram and post-myelogram CT scan. (PX 11)

Petitioner underwent a myelogram/CT on February 11, 2013. The radiologist, Dr. Vyas, noted Petitioner had minimal disc bulges at L4-L5 and L5-S1 with loss of disc concavity. Also noted was a bulging disc extending into the inferior aspects of the neural foramina at these levels resulting in minimal encroachment. The

doctor's impression was low-grade degenerative disc disease L4-5 and L5-S1 with no indication of nerve root impingement. (PX 12)

Dr. Hayden reviewed the CT myelogram on March 19, 2013. Dr. Hayden provided that Petitioner had some mild L5 nerve root irritation. He felt same was not enough anatomically to account for her weakness which was including her ankle plantar flexors. Dr. Hayden indicated that in light of the inconclusive studies on her lumbar spine and progressive weakness of her legs and paraparesis, he wanted to check an MRI of the brain and cervical spine. (PX 21)

On March 20, 2013, Petitioner saw Dr. Li. At that time, Dr. Li noted Petitioner was still having low back pain which radiated into her right leg. Petitioner was continued on pain medication. (PX 14)

At Respondent's request, Petitioner underwent a Section 12 examination with Dr. Van Fleet on April 5, 2013. Petitioner testified Respondent stopped authorization for medical treatment after this exam and report.

Petitioner returned to Dr. Hayden on June 4, 2013. Petitioner continued to complain of symptoms. Dr. Hayden stated that based upon the relatively benign findings on her lumbar spine MRI scan and EMG study, he needed to look further afield for something that would cause significant gait impairment. He continued to request Dr. Li monitor pain medication. The doctor also noted a possible diagnosis of fibromyalgia. (PX 21)

On June 13, 2013, Petitioner saw Dr. Li. The doctor noted that Petitioner was having continuous pain which was sometimes achy and sometimes sharp. Dr. Li noted Petitioner's pain radiated down her left leg to her left foot with tingling and numbness and that standing and walking would increase her pain. Dr. Li recommended that Petitioner obtain a new MRI and he referred Petitioner to a neurosurgeon.

Petitioner testified that in November of 2012, Respondent laid her off from her position. Petitioner said that she began working through a temporary service.

Dr. Li's records indicate that on September 17, 2013, Petitioner requested a note from Dr. Li stating she could work with no restrictions. Petitioner had informed the doctor's office that she intended to go back to work with Abby Placement Services. Records show Dr. Li complied with her request. (PX 15)

Petitioner returned to Dr. Li on October 30, 2013. Petitioner continued to complain of low back pain with radiation to the posterior of both legs. Petitioner also provided that she was unable to stand and walk too long, and that she was unable to work. Dr. Li noted that Petitioner had not undergone the MRI or neurosurgical evaluation that he had recommended as it was not covered by her WC. Dr. Li took Petitioner off work, prescribed that she continue her pain medications, and again recommended that she undergo the MRI and neurosurgical referral. (PX 15)

Petitioner returned to Dr. Hayden on November 4, 2013. Dr. Hayden noted Petitioner did have evidence of mild bilateral L5 radiculopathies but no clear anatomic correlate on her MRI of the lumbar spine. He provided that Petitioner had some lateral recess stenosis, but same did not appear to be capable of causing the degree of neurologic deficits that she was experiencing. Dr. Hayden again recommended MRI imaging of the cervical spine and brain in order to identify a possible cause for Petitioner's lower extremity pain or myelopathy. The doctor recommended continued followup with Dr. Li for low back pain and bilateral mild radiculopathies. (PX 22)

Dr. Li continued his recommendations to remain off work and to undergo an MRI neurosurgical consultation on January 22, 2014 and March 31, 2014. (PX 16, PX 26).

Petitioner testified that on approximately February 3, 2014, she twisted and injured her right ankle. Petitioner treated with Dr. Seidl, an orthopedic surgeon, for a lateral malleolus and posterior malleolar fracture.

Petitioner returned to Dr. Hayden on March 25, 214. Petitioner reported low back pain with numbness and tingling into her legs. Dr. Hayden recommended that Petitioner follow up with Dr. Li. The doctor also prescribed medications of Oxycodone, Soma, Lyrica, and Cymbalta. (PX 23)

With respect to (F.)Is Petitioner's Current Condition of Ill-Being Causally Related to the Injury, the Arbitrator finds as follows:

Dr. Van Fleet testified by deposition on February 5, 2014. Dr. Fleet testified that he evaluated Petitioner on April 5, 2013 at Respondent's request. Dr. Van Fleet stated that Petitioner was 5'9" tall and weighed 274 pounds. Dr. Van Fleet stated that Petitioner was morbidly obese. Dr. Van Fleet stated that on exam, Petitioner could not heel walk or toe walk, but that there was no objective evidence of a foot drop. Dr. Van Fleet stated that Petitioner had symmetric reflexes, but that they were diminished bilaterally to the knees and ankles. Dr. Van Fleet stated that Petitioner gave way to manual motor testing at the knees and ankles which made it difficult to assess her strength accurately. (RX 1, p.p. 9, 10) After reviewing the MRI, myelogram/CT and other medical records, Dr. Van Fleet diagnosed Petitioner with an underlying degenerative back condition with a question of mild radiculopathy. (RX 1, p. 11) Dr. Van Fleet testified that Petitioner's medical treatment prior to his examination was appropriate and that she had reached maximum medical improvement from the work injury. Dr. Van Fleet also felt that Petitioner should engage in an exercise program. (RX 1, p.p. 12, 13)

On cross examination, Dr. Van Fleet stated that theoretically, an inability to heel toe walk could be due to radiculopathy. (RX 1, p.p. 14, 15) Dr. Van Fleet testified that Petitioner had reduced reflexes in her patella and Achilles, however he did not think this was related to Petitioner's accident at work (RX 1, p.p. 15, 16) Dr. Van Fleet acknowledged that the EMG findings on August 22, 2012 revealed mild radiculopathy and that the radiculopathy could cause Petitioner's insertional activity in the peroneus longus and lower lumbar paraspinals. (RX 1, p.p. 16, 17)

Dr. Ji Li testified by deposition taken March 26, 2014. Dr. Li testified that he was a licensed pain specialist and anesthesiologist and that he had been practicing since 1998 in Bloomington. (PX 1, p.p. 3, 4) Dr. Li opined that as a result of Petitioner's December 15, 2011 work accident, she sustained an L4-5 posterior annular tear which gives her a lot of pain. Dr. Li stated that Petitioner had lumbar radiculopathy as a result of her accident. Dr. Li stated that Petitioner's symptoms are worsening and that she needed to have another MRI done and that she needed to be referred to a neurosurgeon for an evaluation. Dr. Li stated that Petitioner was not at maximum medical improvement and that her medical care was not complete. (PX 1, p.p. 11-13).

On cross examination, Dr. Li stated that Petitioner had an annular tear as demonstrated in the MRI. Dr. Li stated that the annular tear could be the source of Petitioner's pain and also may be the reason why her pain is resistant to injections. Dr. Li stated that Petitioner's improvement from her injections were temporary. (PX 1, p. 16)

Petitioner testified that prior to December 15, 2011, she did not have any back or leg pain. Petitioner testified that she had never treated with a medical doctor for her low back or her legs prior to December 15, 2011 accident. She was not on any medications. Petitioner testified that since her accident,

she has experienced ongoing low back and bilateral leg pain which has worsened over time. At the time of arbitration, she was taking a muscle relaxer, Oxycodone for pain, Lyrica, and Cymbalta.

The Arbitrator finds that Petitioner's current condition of ill being is causally related to her December 15, 2011 accident. The Arbitrator relies on the medical records and Dr. Li's opinions and finds that Petitioner likely sustained an annular tear at the L4-5 level, that she aggravated a pre-existing degenerative disc disease which was asymptomatic prior to her December 15, 2011. As a result of the work accident she developed bilateral radiculopathy, as demonstrated by the August 22, 2012 EMG. The Arbitrator finds that Petitioner has not reached maximum medical improvement as a result of her work accident and that she requires further medical care to treat her condition of ill being.

With respect to (G.)What Were Petitioner's Earnings, the Arbitrator finds as follows:

Respondent's Exhibit 2 is the wage statement of Petitioner. Respondent paid Petitioner from April 24, 2011 through December 10, 2011 (33 weeks). Excluded from the calculation is the week of Petitioner's date of accident. Petitioner's work varied between to 20 to 40 hours per week throughout her employment. Petitioner testified that she performed the same job during her entire period of employment with Respondent. For these reasons, all weeks of Petitioner's employment should be considered in the calculation for AWW. Petitioner earned a total of $12,637.65 in straight time wages. Dividing her straight time wages by 33 weeks, provides for an AWW of $382.96.

With respect to (J.) Were the Medical Services That Were Provided to Petitioner Reasonable and Necessary? Has Respondent Paid All Appropriate Charges for All Reasonable and Necessary Medical Services, the Arbitrator finds as follows:

Having found that Petitioner's current condition of ill being is causally related to her December 15, 2011 accident, the Arbitrator orders Respondent to pay the Applied Pain Institute bill of $272 and the McLean County Neurology bill of $110 under the fee schedule.

With respect to (K.) Is Petitioner Entitled to any Prospective Medical Care, the Arbitrator finds as follows:

Dr. Li testified that Petitioner's symptoms were worsening. Dr. Li testified that as a result of the December 15, 2011 accident, Petitioner required a new MRI and a neurosurgical evaluation.

Petitioner testified that she would be willing to undergo another MRI and a neurosurgical evaluation.

The Arbitrator finds that Dr. Li's treatment orders are reasonable and necessary treatment to alleviate the condition caused by her December 15, 2011 accident. The Arbitrator therefore orders Respondent to authorize the MRI, neurosurgical evaluation, and follow up treatment as recommended.

With respect to (L.) What Temporary Benefits (TTD) Are In Dispute, the Arbitrator finds as follows:

Dr. Li took Petitioner off work on October 30, 2013. (PX 15) Dr. Li testified that Petitioner's condition was worsening, that he recommended a new MRI and a neurosurgical evaluation, and that he took Petitioner off work on October 30, 2013, in part, because her treatment was not completed. (PX 1, p. 12)

Dr. Li opined on cross examination that Petitioner may be capable of some type of work, such as sedentary or light duty work, however she could not sit too long or stand too long. Dr. Li stated that prior to releasing Petitioner to return to work, he would recommend that she undergo a functional capacity evaluation to see what type of work she could do. (PX 1, p.p. 21, 22)

Petitioner was laid off from her job with Respondent in November of 2012. Petitioner testified that she had collected some unemployment benefits through May, 2014.

In *Interstate Scaffolding v IWCC*, 236 Ill.2d 132, the Illinois Supreme Court stated that, if an injured worker is not at maximum medical improvement and he is restricted from work activities, he is entitled to TTD benefits even though his employer terminated his employment for cause. In this case, Petitioner was laid off and was not at MMI.

Petitioner testified that as of the date of arbitration, Dr. Li had not released her to return to work.

The Arbitrator therefore awards temporary total disability benefits from October 30, 2013 through the date of the hearing on July 2, 2014.

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

TERRENCE EK,

Petitioner,

vs. NO: 13 WC 33608

RYAN INC. CENTRAL,

Respondent,

15IWCC0667

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, causation, medical, 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, having considered Petitioner's arguments regarding the admissibility of the urine drug tests, finds that they were properly admitted under Section 11 of the Act. We find that the tests substantially complied with Part 9140 of the Illinois Workers' Compensation Rules regarding "Alcohol and Drug Sample Collection and Testing." Furthermore, we find that the hospitals, being licensed facilities, satisfy the requirement of being accredited.

Even if we were to find that the first test, with the sample taken at Sherman Hospital and analysis performed at Quest Laboratories, was inadmissible, we still find that the second test, which was performed "in-house" at the University of Illinois Hospital at 10:35pm on September 7, 2013, is sufficient to create the rebuttable presumption that Petitioner was intoxicated at the time of his alleged injury and that the intoxication was the proximate cause. This urine test was positive for marijuana metabolites with a detection cutoff of 50 ng/ml.

Dr. Leikin testified that the results of the University of Illinois test were consistent with that from Sherman Hospital. He opined that Petitioner had used marijuana within hours of the incident at work and that Petitioner was impaired at the time. The Commission finds Dr. Leikin's opinion credible and more persuasive than that of Dr. O'Donnell in this case.

15IWCC0667

We agree with the Arbitrator that Petitioner has failed to overcome the rebuttable presumption that he was intoxicated at the time of his injury and that the intoxication was the proximate cause of his injury.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 11, 2014, is hereby affirmed and adopted.

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

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

DATED: AUG 2 5 2015

Charles J. DeVriendt

Ruth W. White

Joshua D. Luskin

SE/
O: 8/11/15
49

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

EK, TERRENCE
Employee/Petitioner

Case# **13WC033608**

RYAN INC CENTRAL
Employer/Respondent

15IWCC0667

On 8/11/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4957 Mc NABOLA LAW GROUP PC
TERRANCE M NOFSINGER
55 W WACKER DR 9TH FL
CHICAGO, IL 60601

1296 CHILTON YAMBERT PORTER LLP
DANIEL T CROWE
303 W MADISON ST SUITE 2300
CHICAGO, IL 60606

15IWCC0667

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Terrence Ek
Employee/Petitioner

v.

Ryan, Inc. Central
Employer/Respondent

Case # 13 WC 33608

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 **Lynette Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **June 17, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0667

FINDINGS

On the date of accident, September 7, 2013, Respondent ***was*** operating under and subject to the provisions of the Act.

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

On this date, Petitioner ***did not*** sustain an accident that arose out of and in the course of employment.

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 $**103,833.60**; the average weekly wage was $**1,996.80**.

On the date of accident, Petitioner was **53** years of age, ***married*** with **1** dependent child.

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

Respondent shall be given a credit of $**3,999.60** for TTD, $**0.00** for TPD, $0.00 for maintenance, and $**0.00** for other benefits, for a total credit of $3,996.60.

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

ORDER

The Petitioner was not able to overcome the rebuttable presumption, by the preponderance of the admissible evidence, that the intoxication was not the sole proximate cause or proximate cause of the accidental injury. Therefore, no benefits are awarded, pursuant to the Act.

Respondent shall be given a credit of $3,996.60.

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.

STATEMENT OF FACTS

On September 7, 2013, the date of the alleged accident, Terrence Ek, ("Petitioner") was fifty-three (53) years of age. He was employed by Ryan Inc. Central, ("Respondent"), as a heavy equipment operator. The petitioner had been a journeyman heavy equipment operator for twenty years prior to the alleged date of accident. He was a member of Local 150, International Union of Operating Engineers. The petitioner had been a seasonal employee of the respondent for seven years. Since 2007, the petitioner would operate heavy equipment for the respondent during the construction season. During the winter layoff, the petitioner operated a snowplow for Aero Snow Removal.

The respondent is a mass grading and excavation contractor. At the Sunstar project in Schaumburg, Illinois, the respondent was moving earth, cutting a pond, and building pads.

The petitioner began his seasonal employment with the respondent on May 7, 2013. On that date, in accordance with the terms of the union's contracts with the respondent, the petitioner submitted to a drug test. The said test was negative for cannabinoids (marijuana metabolites) but was positive for amphetamines. When the petitioner was informed that his test was positive for amphetamines, he explained to respondent's personnel that he had been prescribed medication that contained amphetamine, i.e. Vyvanse, by his physician for a condition of ADHD. The petitioner was then allowed to work for the respondent as a heavy equipment operator. The petitioner worked in this capacity for the respondent from May 2013 until August 2013, when he was laid off. The layoff lasted approximately two (2) weeks.

On September 4, 2013, Petitioner was contacted by one of the respondent's superintendents, Mr. Dusty Twite, and advised that he could return to work, effective September 5, 2013, at the Sunstar Project, located in Schaumburg, Illinois. The petitioner accepted the offer and returned to his employment as a heavy equipment operator for the respondent on September 4, 2013. The petitioner operated a Cat and Pan ("Cat") on the first two days, i.e. September 5-6 2013.

Petitioner testified that he reported to work on Saturday, September 7, 2023, at approximately 6:00 a.m. Upon arriving at the job site, he had coffee and made small talk with his co-workers. At approximately 7:00 a.m., they had a "toolbox" talk discussing safety on the job and were told what work they would be doing that day. Petitioner testified that before he began working, he spoke with his superintendent Dusty. They made small talk and talked about the work they were going to do that day. Petitioner further testified that during their conversation, Dusty offered no criticisms of the manner in which Petitioner had been working the prior two (2) days. Dusty also did not say anyone else voiced concerns about the way in which he was doing his work. Tr.pgs. 27-29.

The petitioner began work at the Sunstar site operating the Cat however; it developed a leak in one of its hydraulic hoses. The petitioner brought the Cat back to the area where the equipment is parked

and repaired, known as "the bone yard". At the bone yard, the petitioner was given a Caterpillar 627g Scraper to operate. A Cat 627g Scraper is a wheeled scraper, designed to haul material from one end of a site to another. It weighs approximately 85,000 pounds unloaded, and approximately 125,000 pounds loaded. It is 50 feet long and approximately 12 feet wide; equipped with two engines, one in the front, the other in the rear. The engine in the front has 550 horsepower; the engine in the rear has 350 horsepower. In the cab of the Cat 627 G, the operator sits on an air-assisted, comfort ride seat situated on the left front of the machine. The petitioner testified that he was acquainted with the Cat 627 G scraper and had been operating Cat 627 G scrapers for five years.

The petitioner testified that he did not take any morning breaks and that at around noon on September 7, 2013; he was picking up clay and dirt from the pond to bring it to the fill area on a haul road, when he hit a bump that threw him off his seat. The petitioner testified that after hitting the bump, he was launched up and down; the seatbelt he was wearing kept him "locked". He further testified that the seat "bottomed out" and he immediately experienced pain in his low back; and that his legs went numb. The petitioner stated that he got out of the Cat 627g scraper and tried to stretch out. He then decided to lay down. This occurrence was not witnessed.

Petitioner further testified that two other scrapers approached the petitioner, who was laying on the ground, however, the petitioner waved them on. A few minutes later a foreman stopped by the petitioner, made inquiries, and then drove the petitioner to his truck. The petitioner testified that he sat in his truck for a while but was not getting any better. The foreman then drove the petitioner to an immediate care facility in the area. The petitioner testified that he was unable to get out of the foreman's truck at the immediate care facility so an ambulance was called, which took him to Sherman Hospital.

Respondent's first witness, Mr. Dusty Twite

Mr. Dusty Twite testified that he was Respondent's superintendent at the Sunstar site, on September 7, 2013; and had been employed by the respondent for twenty-six (26) years. He had known Petitioner as an operator for about a year before the incident. In September 2013, they were working on a project for Sunstar Manufacturing in Schaumburg, Illinois. The job consisted of mass grading for a building pad, roads and ponds for the Sunstar Building Project. Tr. pgs. 120-122.

He testified that September 7, 2013 was a Saturday and they began work at approximately 7:00 a.m. He recalled meeting with the crew and discussing safety and the duties they were to perform that day, but not personally speaking with Petitioner. His recollection was that Respondent's crew was going to take material out of an area that would become a pond. He did not recall whether a lunch was taken that day. He testified that he was contacted on his cell phone by the foreman and told that Petitioner was lying on the ground, in the area of a scrapper. Mr. Twite immediately drove his pickup truck to the scene where he found the petitioner lying on the ground in a fetal position, approximately fifteen

(15) feet away from the scraper. Mr. Twite stated that he arrived at the scene between 11:00 a.m. and 11:30 a.m. Tr. pgs .124-125.

Mr. Twite testified that he spoke to Petitioner who stated he thought he pulled a muscle and he would be fine; and he wanted to go to his vehicle so he could go home. Petitioner did not tell him what happened. Tr. pgs. 125-126.

Mr. Twite took photographs of the premises approximately three (3) hours after the incident. Mr. Twite inspected the area where he found the Petitioner and he did not see anything "out of the normal." but he did see a few ruts. (p. 126-129).

Mr. Twite had seen scrappers operated for a number of years while at Ryan. He was familiar with their operation but he only supervised their operators. Mr. Twite testified he had never run a scrapper in production but had moved them in the bone yard.

Mr. Twite testified that he did not see anything at the scene where he found the scrapper that would cause it to jump. Mr. Twite was shown the photographs marked, as Respondent's to Exhibit 5. He testified concerning the direction various photographs were taken and their location on the job site. He testified that photograph number 3 showed the area where he found Petitioner and his scrapper. He used a pen to circle the area where he found the vehicle. He testified to walking towards the camera where he found the scrapper.

Mr. Twite further testified that when he walked back towards the pond he did not see anything out of the normal that would cause the scrapper to jump. And that Photograph number 5 showed the ditch area in the pond. Mr. Twite marked the area where he found the Petitioner in his scrapper. He also marked photograph number 6 where he claimed to find Petitioner in the scrapper. He did the same for exhibit number 8. He testified that he has never studied accident site investigation. Tr. Pgs.143-144. The petitioner testified that none of the photographs depicted the area in which he was injured.

Mr. Twite does not operate heavy machinery for Respondent and his role is supervisory only. He relies upon the expertise of his operators when running machines. He has had to move machines before but never actually run one in production. He testified that he has never been in the cab of a scrapper, working a job site. Mr. Twite has seen operators using scrappers and observed them in the cabs. From time to time, he has observed operators and cabs of heavy equipment on job sites being bounced around from rough terrain.

Mr. Twite testified that he did not recall speaking directly with Petitioner on the morning of the incident however, he does remember seeing him. He did not make any observations of Petitioner, on

the morning of the incident, that indicated the petitioner might have been under the influence of drugs or alcohol.

When Mr. Twite walked up to Petitioner, he was laying on the ground in a fetal position. He could tell Petitioner was in pain by the position he was laying in and the expression on his face. While at the scene, Mr. Twite did not have any conversation with Petitioner concerning how he was injured because he was more worried for his wellbeing.

Mr. Twite did not ask Petitioner where his injury occurred before taking the photographs depicted in Respondent's Exhibit 5. He does not have any knowledge about where the actual bump happened. He agreed that not every section of the haul road was depicted in the photographs he took and there are portions of the haul road not shown in any of the photographs. He agreed that the photographs do not depict the entire area where the petitioner may have been injured. None of the photographs showed the area where he found the Petitioner in the machine because someone had moved the machine before he took the photographs. Also, Mr. Twite did not dispute that there were no breaks or lunch breaks taken before Petitioner was injured.

Mr. Twite agreed that the cut area, the haul road and dump area present risk of bumps to drivers of heavy machines. He also agreed there were ruts and rocks in some areas. He agreed those are the type of things that someone normally sees when doing this type of work on the job where Petitioner was injured. He agreed that none of those things would be out of the ordinary or would be unusual for an operator to encounter.

Mr. Twite did not dispute the Petitioner was operating the scrapper and hit a bump which caused injury to his back. In Mr. Twite's entire investigation into the accident, he did not find any evidence whatsoever that operator error contributed to cause it. Mr. Twite testified after Petitioner was injured the job continued. Scrappers continued to take dirt out of the cut and the cut kept expanding. He agreed scrappers dropped dirt and rock from time to time, as they are transporting it.

Mr. Twite testified he had never been involved in accident investigation before. He testified that when walking the job site after the injury he was looking for anything out of the norm but he did not find anything. Tr. pgs. 145-159.

Mr. Twite testified to going to Marian Joy Rehabilitation Hospital to see Petitioner. He spoke to him mostly about how he was feeling. His recollection was that Petitioner said he was coming out of the pond then there was a sudden jar. Tr. pgs. 127-142.

Respondent's second witness, Mr. Steven Pierce

The respondent asked its mechanic, Mr. Steven Pierce, to inspect the Cat 627g scraper that was involved in the occurrence. Mr. Pierce testified that he performed his inspection on September 9, 2013. Mr. Pierce is a field mechanic who has been in the respondent's employ for three years. His job responsibilities include repairing heavy equipment and making sure it can be operated in a safe manner. Mr. Pierce is a member of Local 150 and has been in the field for 27 years.. In addition to being a field mechanic, he is also a heavy equipment operator. He has multiple certifications as a heavy equipment mechanic from manufacturers such as Komatsu and Caterpillar. Mr. Pierce has been operating and repairing Cat 627g scrapers for ten years, since they were first placed on the market.

Mr. Pierce examined the operator's seat of the subject scraper and found nothing wrong. Further, Mr. Pierce operated said 627g scraper. Mr. Pierce stated that when he took it out on September 9, 2013, and ran it harder than the normal operator would. He did so in an attempt to determine the cause, if any, of the occurrence. Specifically, while operating the said scraper, Mr. Pierce tried to bottom out the seat. Mr. Pierce testified that he was not able to bottom out of the seat and that the said Cat 627g scraper was functioning normally. After the said scraper passed his inspection, he put it back into operation.

The petitioner testified that while he was on layoff, for approximately two weeks in August of 2013, he smoked marijuana three times a day each day of the layoff. He testified that he stopped smoking marijuana on September 4, 2013, after being notified by Mr. Twite that he was to return to work the next day. The petitioner denied that he had smoked any marijuana after September 4, 2013, and specifically denied that he smoked marijuana on September 7, 2013.

The petitioner testified that he was aware that marijuana remains in one's system for a period of time after ingestion. He further testified that he knew if he were drug tested after he returned to work on September 5, 2013, he could have tested positive for the presence of marijuana in his system.

Pursuant to the terms of Local 150's contract with the respondent, urine was drawn from the petitioner, by way of a catheter, for the purpose of determining whether the petitioner had any controlled substances in his system. The urine was drawn from the petitioner at the Sherman Hospital at 5:10 p.m., approximately 4-5 hours after the occurrence. The drug screen performed on the petitioner's urine revealed the presence of marijuana metabolites in the petitioner's system at a value of greater than 300 ng/ml. The urine test also revealed the presence of amphetamines at a value greater than 10,000 ng/ml.

The petitioner transferred from Sherman Hospital to the University of Illinois Hospital on September 7, 2013. A drug test was performed at the University of Illinois Hospital at 10:35 p.m. on September 7,

2013, by order of the petitioner's physician at the University of Illinois, at approximately 10:35 p.m. It was not requested by the respondent. The test indicated the presence of cannabinoids in the petitioner's system at a value greater than 50 ng/ml.

The petitioner denied using any illicit drugs to the emergency room personnel at the Sherman Hospital and the personnel at the University of Illinois Hospital. The petitioner also denied using any illicit street drugs to the adjustor, Ms. Lori Lighthizer, from TriStar Risk Management, the respondent's workers' compensation administrator, in a statement he gave to her on September 11, 2013, Petitioner testified that he was under the influence of strong analgesics at Sherman Hospital and does not remember giving Ms. Lighthizer any statement. The medical records support that the Petitioner was given morphine at the hospital. In his direct testimony, the petitioner denied ever having tested positive for a controlled substance. The records from the Sherman Hospital demonstrate that the petitioner underwent a toxicology screen on April 16, 2013; the screen revealed the presence of THC in his system. Rx18.

Deposition of Dr. Jerrold Blair Leikin taken April 21, 2014

The respondent retained Dr. Jerrold Leikin, a medical toxicologist and physician, as its Section 12 examiner. Dr. Leikin is board certified in internal and emergency medicine. He is a medical toxicologist and a certified medical review officer. He is a professor of medicine at Rush Medical College, a professor of pharmacology at the Rush Medical College, and a clinical professor of medicine at the University of Chicago, Pritzker School of Medicine. Dr. Leikin explained that the role of the medical toxicologist is to determine the adverse effects of drugs and chemicals on the human body. Dr. Leikin was retained by the respondent to determine whether the petitioner was intoxicated and impaired at the time of the occurrence on September 7, 2013, as a result of his ingestion of marijuana.

Dr. Leikin's testimony opines that petitioner had ingested marijuana on September 7, 2013 and that this conclusion is confirmed by the amount of marijuana metabolites present in the petitioner's system, five, then ten hours after the occurrence. Dr. Leikin was aware of the petitioner's examination with Dr. O'Donnell; where he told of his use of marijuana, in the three-week period prior to September 7, 2013. Dr. Leikin testified that an individual of the petitioner's weight would not have had the enormous amount of marijuana metabolites in his system, as shown by the tests taken at Sherman and University of Illinois hospitals, if he had abstained from its use for a period of three days.

Dr. Leikin stated, that marijuana causes in-coordination, impaired judgment, increased reaction time, and perceptual abnormalities; and for a chronic smoker, withdrawal symptoms. He testified that he performed a records review of the petitioner's medical records from the Sherman Hospital and the University of Illinois Hospital.

Based on the drug screen tests performed at the Sherman Hospital four to five hours after the occurrence, Dr. Leikin stated that the value of marijuana metabolites of greater than 300 ng/ml was enormous and compatible with use of marijuana within hours of the time that the test was administered. Dr. Leikin opined that at the time of the occurrence, at approximately 1:00 p.m. on September 7, 2013, the petitioner was impaired due to his ingestion of marijuana, and at an increased risk for being involved in an accident. Dr. Leikin stated the basis of this opinion was the enormous amount of marijuana in his system, his knowledge of the pharmacology of marijuana, the duration of action of this substance; along with the impairing capabilities of this substance. which causes in-coordination, impaired judgment, increased reaction time, perceptual and visual abnormalities.

In addition, Dr. Leikin, testified that as a certified medical review officer, if he had been aware that an individual had marijuana metabolites in his system, at a value greater than 300 ng/ml; he would have been obligated to pull the person off the job, to prevent an accident.

Dr. Leikin stated that the value of 300 ng/ml was enormous. He explained that this value is, at least, twenty times greater than the cut-off of 15 ng/ml. Dr. Leikin also reviewed the urine drug screen that was performed at the University of Illinois Hospital at 10:35 p.m. on September 7, 2013. This test showed a value of, at least, 50 ng/ml. This confirmed Dr. Leikin's opinions and supported his contention that the petitioner used marijuana on September 7, 2013. RX1 pgs. 6-110.

Deposition of Dr. James O'Donnell taken, March 6, 2014

The petitioner's attorney retained Dr. James O'Donnell, a pharmacologist, as its Section 12 examiner. Dr. O'Donnell is not a medical doctor nor is he a certified medical review officer. Dr. O'Donnell received a Bachelor of Science degree in pharmacy at the University of Illinois in 1969. He then took a course of study in pharmacology at the University of Michigan where he received a doctor of pharmacology degree in August of 1971. Dr. O'Donnell has testified at trial approximately three hundred fifty (350) times and has given approximately four hundred (400) depositions.

Dr. O'Donnell testified that he spoke with the petitioner on February 6, 2014, at which time the petitioner told him that he smoked two pipefuls of marijuana per day while he was on layoff in August of 2013, but that he ceased smoking marijuana four days prior to September 7, 2013. Dr. O'Donnell acknowledged the value of greater than 300 ng/ml found in the petitioner's urine sample given at the Sherman Hospital on September 17, 2013. Dr. O'Donnell testified that the petitioner is a chronic user of marijuana and that marijuana metabolites will remain in the system of a chronic user for a relatively long period after use. Dr. O'Donnell testified that the test that was performed on September 7, 2013, at the Sherman Hospital only tested for marijuana metabolites, not for Delta 9 THC, the active ingredient in marijuana that causes "the high", and that it was not competent evidence to support the proposition that the petitioner was intoxicated at the time of the occurrence on September 7, 2013.

The petitioner denied that he was aware of the specific provisions of the "uniform drug/alcohol abuse program" contained in his union's contract with the respondent. The petitioner admitted to a general understanding of the prohibition of the use of drugs and alcohol on the job.

In the said union contract, Respondent's Exhibit #2 IV, it states as follows:

1. Rules-All employees must report to work in a physical condition that will enable them to perform their jobs in a safe and efficient manner. Employees shall not
    a. Use, possess, dispense or receive prohibited substances on or at the job site;
    b. Report to work with any measurable amount of prohibited substance in their system.

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

A decision by the Commission cannot be based upon speculation or conjecture. *Deere and Company v Industrial Commission*, 47 Ill.2d 144, 265 N.E. 2d 129 (1970). A petitioner seeking an award before the Commission must prove by a preponderance of credible evidence each element of the claim. *Illinois Institute of Technology v. Industrial Commission*, 68 Ill.2d 236, 369 N.E.2d 853 (1977). Where a petitioner fails to prove by a preponderance of the evidence that there exists a casual connection between work and the alleged condition of ill-being, compensation is to be denied. Id. The facts of each case must be closely analyzed to be fair to the employee, the employer, and to the employer's workers' compensation carrier. *Three "D" Discount Store v Industrial Commission*, 198 Ill.App. 3d 43, 556 N.E.2d 261, 144 Ill.Dec. 794 (4th Dist. 1989).
The burden is on the Petitioner seeking an award to prove by a preponderance of credible evidence all the elements of his claim, including the requirement that the injury complained of arose out of and in the course of his or her employment. *Martin vs. Industrial Commission*, 91 Ill.2d 288, 63 Ill.Dec. 1, 437 N.E.2d 650 (1982). The mere existence of testimony does not require its acceptance. *Smith v Industrial Commission*, 98 Ill.2d 20, 455 N.E.2d 86 (1983). To argue to the contrary would require that an award be entered or affirmed whenever a claimant testified to an injury no matter how much his testimony might be contradicted by the evidence, or how evident it might be that his story is a fabricated afterthought. *U.S. Steel v Industrial Commission*, 8 Ill.2d 407, 134 N.E. 2d 307 (1956).
It is not enough that the petitioner is working when an injury is realized. The petitioner must show that the injury was due to some cause connected with the employment. *Board of Trustees of the University of Illinois v. Industrial Commission*, 44 Ill.2d 207, 214, 254 N.E.2d 522 (1969); see also *Hansel & Gretel Day Care Center v Industrial Commission*, 215 Ill.App.3d 284, 574 N.E.2d 1244 (1991).

The Illinois Supreme Court has held that a claimant's testimony standing alone may be accepted for the purposes of determining whether an accident occurred. However, that testimony must be proved credible. *Caterpillar Tractor vs. Industrial Commission*, 83 Ill.2d 213, 413 N.E.2d 740 (1980). In addition, a claimant's testimony must be considered with all the facts and circumstances that might not justify an award. *Neal vs. Industrial Commission*, 141 Ill.App.3d 289, 490 N.E.2d 124 (1986). Uncorroborated testimony will support an award for benefits only if consideration of all facts and circumstances support the decision. *See generally, Gallentine v. Industrial Commission*, 147 Ill.Dec 353, 559 N.E.2d 526, 201 Ill.App.3d 880 (2nd Dist. 1990), *see* also *Seiber v Industrial Commission*, 82 Ill.2d 87, 411 N.E.2d 249 (1980), *Caterpillar v Industrial Commission*, 73 Ill.2d 311, 383 N.E.2d 220 (1978). It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical evidence, and assign weight to the witness' testimony. *O'Dette v. Industrial Commission*, 79 Ill.2d 249, 253, 403 N.E.2d 221, 223 (1980); *Hosteny v Workers' Compensation Commission*, 397 Ill.App. 3d 665, 674 (2009).

Section 11 of the Illinois Workers' Compensation Act provides, in part, as follows:
No compensation shall be payable if: (i) The employee's intoxication is the proximate cause of the employee's accidental injuries....if at the time of the accidental injuries....there is any evidence of impairment due to the use of unlawful or unauthorized use of (i) cannabis as

> defined by the Cannabis Control Act....then there shall be a rebuttable presumption the employee was intoxicated and that the intoxication was the proximate cause of the employee's injury. The employee may overcome the rebuttable presumption by the preponderance of the admissible evidence that the intoxication was not the sole proximate cause or proximate cause of the accidental injury.

The petitioner admitted to Dr. O'Donnell, that he had been a chronic user of marijuana. Yet when he was asked by the personnel at the Sherman Hospital on September 77, 2013, whether he used illicit drugs, he denied it. In his testimony, the petitioner stated that he could not recall being asked the question. He gave the same answer at trial about the statements of denial he made at the University of Illinois Hospital and to the respondent's insurance adjustor.

The Cat 627 G scraper the petitioner was operating at the time of the occurrence was inspected by Mr. Steven Pierce after the accident. The purpose of Mr. Pierce's inspection was to find a cause of the occurrence. Not only did Mr. Pierce perform an inspection of every part of the scraper, he also operated it and worked it harder than normal in order to determine if he could duplicate it "bottoming out". He testified that the scraper was functioning properly.

The Arbitrator finds that Respondent expert, Dr. Leikin, is more persuasive than Petitioner's expert, Dr. O'Donnell. Dr. Leikin credentials includes an array of certifications, most importantly he is a professor of Pharmacology and certified as an medical review officer, focusing on medical toxicology. While the Arbitrator has no doubt that something happened, on the job, that caused a significant injury to Petitioner's spine; he was able to stand, talking with his co-workers before the incident, with no noticeable signs of injury; the Arbitrator finds and concludes that there was evidence of marijuana present in the petitioner's system, at the time of the accident. The significant question is whether the petitioner was able to overcome the rebuttable presumption, by the preponderance of the admissible evidence, that the intoxication was not the sole proximate cause or proximate cause of the accidental injury. The Arbitrator concludes that the petitioner has not overcome this presumption. Therefore, no benefits are awarded pursuant to the Act. All other issues are moot and will not be addressed.

15IWCC0667

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
13 WC 33608
SIGNATURE PAGE

Signature of Arbitrator

August 11, 2014
Date of Decision

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tina Kosicek,

Petitioner,

15IWCC0668

vs.

NO: 03 WC 37076

East Aurora High School,

Respondent.

DECISION AND OPINION ON REMAND

This matter had previously been heard and the Decision of the Commission had been filed October 18, 2007. The Commission Decision affirmed the Arbitrator's Decision filed on January 18, 2007. Petitioner was awarded 28-6/7 weeks of temporary total disability benefits at a rate of $611.07 per week under §8(b) of the Act, $1,500.00 for reasonable and necessary medical expenses provided by Hinsdale Orthopedic Services and $1,971.35 for other medical expenses under §8(a) of the Act, and permanent partial disability (PPD) benefits for 137.5 weeks at $542.17 per week = $74,548.38 total PPD due to a 27.5% loss of use of her person as a whole under §8(d)(2) of the Act. This award stemmed from a May 28, 2003 work-related back injury.

Petitioner filed a §19(h)/8(a) Petition on June 12, 2009. Petitioner argued that her condition of ill-being in 2009 was causally related to her condition at Arbitration on January 4, 2007, which was found by the Commission to be causally related to her May 28, 2003 accident. Petitioner also argued that her disability had recurred or increased since the entry of the Commission's Decision, and that she was entitled to payment for outstanding medical bills, temporary partial disability (TPD) benefits, temporary total disability (TTD) benefits, and wage differential benefits pursuant to §19(h)/8(a) of the Act and that Respondent shall be liable for penalties and fees.

15IWCC0668

FACTUAL BACKROUND

During the Arbitration hearing in January of 2007 Petitioner was teaching at Lockport High School full time. From August 2007 through February 2008 she taught Conceptual Chemistry at Reed Custer High School. During this time she testified that her back pain became more severe. She also testified that she resigned in February 2008, due to her back pain and her resistance to administrations push to change a student's grade.

Between July 2004 and December 2008 Petitioner sought no medical treatment for her back. However she testified that her back pain gradually progressed from 2007 to 2008. She began teaching part time as an Adjunct faculty member at Joliet Junior College in January of 2008. Shortly thereafter, she underwent a lumbar MRI with Dr. Lorenz. On January 7, 2009 she was prescribed pain medication, started on physical therapy and was taken off work. She decided to continue teaching 2 days a week for that semester, however. She also worked the 2009-10 school year, earning $4,354.00.

Respondent's Independent Medical Examiner, Dr. Goldberg, examined Petitioner in August 2009 and recommended back surgery, which Petitioner eventually underwent June 25, 2010. Dr. Goldberg noted that Petitioner's 2008 MRI did not reveal any herniation. It only revealed a degenerative disc at L5-S1 along with modic changes, which are changes within bone marrow on either side of a disc that are consistent with a degenerative process. He opined that a posterior fusion at L5-S1 (eventually performed in June 2010) would be an appropriate treatment. However he did not believe Petitioner's condition was causally related to the 2003 accident. Petitioner had improvement in her radicular pain after undergoing a discectomy and she did not receive any treatment between July 2004 and December of 2008. Dr. Goldberg opined that a causal relationship would require ongoing symptomatology and, most commonly, additional medical treatment. Dr. Goldberg noted that the fusion was not necessary, but it was a quality of life option for Petitioner.

In August 2010 Petitioner was in an automobile accident, but claims that she did not injure her back in it. She also claimed that Dr. Lorenz's records are incorrect if they reflect that she suffered a low back strain as a result of the accident.

Petitioner underwent a Functional Capacity Evaluation (FCE) IN THE Spring of 2011. Dr. Lorenz imposed permanent restrictions of 15 pounds lifting, 4-5 hours of work per day if a standing or sitting job, with intermittent breaks every 35-40 minutes. If it were a walking job, Petitioner could only work 3 hours per day. Petitioner took off work from June 21, 2010 through August of 2011, when she was re-hired by Joliet College, earning $3,315.00 per semester.

Had Petitioner been employed by Respondent in the 2008-09 school year, she would have been a step 11 and earned $50,359.00. In 2009-10, Petitioner would have earned $52,373.00. In the 2011-12 school year, Petitioner would have earned $56,623.00.

Petitioner reiterated that her back and leg pain improved significantly after her 2010 fusion. She still has intermittent right leg pain, however.

15IWCC0668

ORDER ON REMAND

The Commission finds that there is no objective evidence supporting Petitioner's §19(h)/8(a) claim. Although the 2011 FCE indicates a worsening of her symptoms, it was not reliable, as Petitioner had not undergone work hardening. Thus, an accurate determination of her disability level could not be found. Additionally, Dr. Goldberg did not agree with the opinion of Dr. Lorenz regarding causation, and in fact noted that there was a lack of continuity in Petitioner's complaints, indicated by Petitioner's 4-and-a-half year period without treatment from 2004 to 2008.

While the Commission finds no basis in the record, facts or law, to alter its Decision, it does so in accordance with the Circuit Court Order.

At the time of the Arbitration Decision on January 18, 2007, Petitioner was working full time and was not seeking any medical treatment related to the back injury in question. This held true until Petitioner sought treatment on December 4, 2008.

Regarding TPD, Petitioner was taken off work by Dr. Lorenz on January 7, 2009, however she went back to work January 13, 2009 and continued working 2 days a week for the remainder of the 2008-09 school year as well as the entire 2009-10 school year up until May 6, 2010. In August 2011 Petitioner resumed working 2 days a week for a total of 4 hours and 20 minutes per week.

From January 13, 2009 through May 5, 2009 Petitioner earned $4,020.00 or $249.07 per week working part time for Joliet. She would have earned $1,207.36 per week during the same period if employed by Respondent. Thus, she sustained a wage loss of $958.29 per week and is due TPD benefits of $638.86 per week for the period of 16-1/7 weeks, or $10,311.20.

From August 25, 2009 through December 10, 2009, Petitioner earned $282.18 per week at Joliet, whereas she would have earned $1,281.77 per week at East Aurora. This is a wage loss of $999.59, which equates to TPD benefits of $666.39 per week for 15-3/7 weeks, or $10,282.40. From January 12, 2010 through May 6, 2010 Petitioner claims TPD benefits of $11,137.08.

Regarding TTD, Petitioner was off of work from January 7, 2009 through January 12, 2009, as well as the entire 2010-11 school year.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's current condition of ill-being is causally related to the accident in question

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to all reasonable and necessary medical expenses related to her back injury from December 4, 2008 through September 21, 2011.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to 52-6/7 weeks of TTD benefits at a rate of $611.07 per week (January 7, 2009 through January 12, 2009; and 52 weeks for the 2010-11 school year).

15IWCC0668

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner is entitled to TPD benefits in the amount of $31,730.68.

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

DATED: AUG 2 5 2015
DLG/wde
O: 8/6/15 (Discussion)
45

David L. Gore

Mario Basurto

Stephen Mathis

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Perry James,

Petitioner,

vs. NO: 10 WC 36222

CCS Utilities,

Respondent,

15IWCC0669

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 medical, prospective medical, temporary total disability, causal connection, permanent partial disability, vocational rehabilitation 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 November 19, 2014 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.

15IWCC0669

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

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

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

DATED: AUG 25 2015

MB/mam
o:7/9/15
43

Mario Basurto

David L. Gore

Stephen Mathis

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

PEERY, JAMES
Employee/Petitioner

Case# **10WC036222**

15IWCC0669

CCS UTILITIES
Employer/Respondent

On 11/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.07% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

3259 McCREADY GARCIA & LEET ASSOC
EDWIN REYES
10008 S WESTERN AVE
CHICAGO, IL 60643

0507 RUSIN & MACIOROWSKI LTD
JOHN MACIOROWSKI
10 S RIVERSIDE PLZ SUITE 1530
CHICAGO, IL 60606-3833

15IWCC0669

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)

James Peery
Employee/Petitioner

v.

CCS Utilities
Employer/Respondent

Case # **10** WC **36222**

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 **Joshua Luskin**, Arbitrator of the Commission, in the city of **Chicago**, on **October 16, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

15IWCC0669

FINDINGS

On the date of accident, **9/9/2010**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

The parties stipulated that in the year preceding the injury, the petitioner earned $**104,000.00** and that pursuant to Section 10 of the Act his average weekly wage was $**2,000.00**.

On the date of accident, Petitioner was **31** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of $**198,702.41** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**198,702.41**.

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

ORDER

The respondent shall pay the petitioner temporary total disability benefits of $1,243.00/week (statutory maximum TTD rate) for 159 & 2/7 weeks, from September 9, 2010, through September 27, 2013 (MMI), inclusive, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $198,702.41 for disability benefits paid to date.

Vocational rehabilitation and maintenance are denied for reasons set forth in the attached decision.

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

November 19, 2014
Date

ICArbDec19(b)

NOV 19 2014

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES PEERY, Petitioner,	)	
vs.	)	No. 10 WC 36222
CCS UTILITIES, Respondent.	)	

ADDENDUM TO ARBITRATION DECISION

This matter was heard pursuant to Section 19(b) of the Act.

STATEMENT OF FACTS

The petitioner began working for the respondent as a general foreman and electrician on August on or about August 10, 2010. The petitioner testified that up to the day before his employment with the respondent, he had worked for SPE Utilities that summer, and before that worked several weeks for MJ Electric. The durations of his jobs varied in accordance with the nature of the job, the extent of the projects, and so on. Regarding his work for the respondent, the petitioner's supervisor, Joe Wirtz, prepared a written job description which was admitted as RX1.

On September 9, 2010, the petitioner was injured in a fall from a height, resulting in an open fracture and dislocation of his left arm at the elbow. He was taken by ambulance to Lutheran General Hospital, where he was admitted. He underwent surgical procedures with Dr. Ferlit on September 9, 10 and 13 involving open reduction/internal fixation and incision and drainage of the wound with irrigation, debridement and wound closure, followed by placement of a cast and sling. He was discharged from the hospital on September 14 with instructions to follow up with the orthopedist. See PX1, PX2.

On September 17, 2010, he saw Dr. Ferlit and was recasted. On September 27, he returned to Dr. Ferlit. At that time, Dr. Ferlit assessed a posterior subluxation of the radial head in the cast. Dr. Ferlit recommended a closed reduction under anesthesia, which was performed later that day. The petitioner saw Dr. Ferlit the next day, and Dr. Ferlit modified the cast and noted no excessive swelling. Dr. Ferlit prescribed medication, range of motion exercise and a follow up. See PX7. The petitioner underwent physical therapy at Loyola. On November 1, 2010, Dr. Ferlit released the petitioner to right-hand work with no driving. On November 29, 2010, Dr. Ferlit noted improved range of motion and removed the "no-driving" restriction. PX7.

On January 12, 2011, the petitioner reported some swelling but X-rays noted progressive union. He was maintained on an exercise regimen. On February 14, 2011, Dr. Ferlit noted some restriction with extension and flexion and maintained him in therapy. Restrictions were modified to 15 pounds lifting and no ladder climbing. PX7.

On March 1, 2011, Dr. Kevin Walsh saw the petitioner at the respondent's request pursuant to Section 12 of the Act. Following his evaluation and review of the medical records, Dr. Walsh did note some restricted range of motion on examination regarding flexion and extension. He recommended consideration of an FCE. RX3.

On March 17, 2011, Dr. Ferlit recommended work hardening, followed by an FCE. On April 20, 2011, the petitioner reported the work hardening was causing the elbow to stiffen up. It was noted an FCE was pending. See PX7.

On May 9, 2011, the petitioner underwent a FCE. It was noted that there were some inconsistencies between the petitioner's subjective reports of pain and limitation and the petitioner's objective performance. Overall, the petitioner did demonstrate the majority of the requirements to do his regular job, but his grip strength was viewed as deficient and he presently lacked the occasional lifting strength requirement; it was noted that these remained subject to improvement. PX8.

On May 13, 2011, the petitioner saw Dr. Preston Wolin for evaluation. Following evaluation, Dr. Wolin recommended the petitioner see a colleague, Dr. Goldberg. PX8.

The petitioner saw Dr. Goldberg on May 20, 2011. Dr. Goldberg reviewed the X-rays and assessed a malunion of the proximal ulna, and opined the plate and screws might fail and the present placement likely contributed to the range of motion loss. Dr. Goldberg also noted neurologic symptoms consistent with ulnar nerve neuropathy at the left elbow. Dr. Goldberg recommended revision surgery, including removal of the problematic hardware and ulnar nerve transposition. PX10, RX5. The petitioner concurred, and on June 28, 2011, Dr. Goldberg performed left elbow surgery to remove the hardware, revise the ORIF and release the cubital tunnel. See PX13.

On July 1, 2011, Dr. Goldberg saw the petitioner and noted improved sensation in the fingertips. Dr. Goldberg recommended aggressive range of motion therapy and provided medication and a bone stimulator. The petitioner underwent physical therapy thereafter. On August 8, 2011, the petitioner reported improved range of motion and X-rays showed good position of the hardware. Dr. Goldberg maintained physical therapy and bone stimulator use and released him to work with no use of the left arm. Those prescriptions were maintained on September 12, 2011. On October 10, 2011, Dr. Goldberg noted some healing in the bone and instructed the petitioner to continue use of the bone stimulator. On November 21, 2011, Dr. Goldberg noted no progression in the bone healing, and recommended a bone grafting procedure. See generally PX10.

The respondent secured a Section 12 examination with Dr. Vender on December 22, 2011. Following examination, Dr. Vender concurred with the bone autograft procedure and ongoing postoperative use of the bone stimulator. See RX8.

On January 31, 2012, Dr. Goldberg performed a revision ORIF surgery with bone grafting and placement of an internal bone stimulator. See PX13. On February 3, 2011, Dr. Goldberg prescribed physical therapy, and on March 5, 2012, the petitioner reported stiffness in the arm and tightness in the hand, but had full grip strength. Dr. Goldberg released him to right-handed work. PX10. On April 9, 2012, the petitioner reported improvement in pain and range of motion, and the prescriptions for physical therapy and one-hand work were maintained. PX10.

On May 14, 2012, repeat X-rays were done and Dr. Goldberg noted bone healing being shown. He recommended ongoing therapy. PX10. On June 25, 2012, the petitioner was noted as progressing but had not fully healed. Dr. Goldberg recommended tapering off the narcotic medication and instructed him to follow up. PX10.

On August 6, 2012, the bone had still not healed. Dr. Goldberg suggested several further options including conservative care, removal of the hardware, and potential further bone grafting. Dr. Goldberg then referred the petitioner to a colleague, Dr. Gonzalez, for another opinion, but instructed him to follow up as well. PX10, RX9.

On August 10 and August 31, 2012, Dr. Mark Gonzalez saw the petitioner and discussed the potential for a vascularized bone grafting procedure. On August 31, the petitioner was instructed to get a CT scan prior to determination of whether to pursue the surgery. PX11. The petitioner underwent the CT scan on October 23, 2012. It noted the expected postoperative changes but demonstrated a residual fracture line with favorable progression of the bone union. On October 26, 2012, Dr. Gonzalez reviewed the CT scan and opined that the healing demonstrated was "quite encouraging" and recommended ongoing observation with a repeat CT scan in ten weeks. PX11.

The repeat CT scan was performed on January 7, 2013 and was compared to the earlier CT scan and X-rays. It suggested "significant overall healing" of the fracture with stable placement of the stimulator. RX12. On January 11, 2013, Dr. Gonzalez reviewed the CT and opined that continued healing had been demonstrated, and recommended ongoing observation rather than attempting another surgery. PX10, PX11.

On May 24, 2013, the petitioner was seen by Dr. Goldberg. New radiographs demonstrated significant improvement in the bone healing, and the petitioner was scheduled for removal of the bone stimulator. PX10. That day, the petitioner also saw Dr. Gonzalez, who noted that the petitioner had been placed on restrictions of five pounds lifting, pushing, pulling or carrying with the left hand, and instructed the petitioner to follow up in three months. PX11, RX13. On August 23, 2013, the petitioner saw Dr. Gonzalez, who noted good healing identified on radiographs, and recommended removal of the bone stimulator. PX11.

The petitioner was seen by Dr. Walsh for a second Section 12 examination on September 8, 2013, at the respondent's request. After his review of the medical records following his first examination, Dr. Walsh opined that the CT scans showed good alignment of the fracture. Dr. Walsh noted no further medical treatment was needed, though the bone stimulator could be removed. Dr. Walsh also observed surveillance of the claimant (which will be discussed further below) and opined that the claimant's observed behavior was in excess of the claimant's subjective complaints and asserted limitations. Dr. Walsh opined that the claimant would effectively be at MMI and would be able to work his regular duty. See generally RX17.

On September 19, 2013, Dr. Gonzalez performed surgery to remove the bone stimulator, noting the petitioner had done "extremely well" to that point. PX11, RX14. On September 27, 2013, Dr. Gonzalez saw the petitioner in follow-up and noted the petitioner was doing well postoperatively, and opined the petitioner was at MMI at that time. He did instruct the petitioner to return in six months, but did not indicate for what purpose, and made no recommendations for further treatment. He deferred any work restrictions to Dr. Goldberg's earlier assessment. PX11, RX15.

The claimant was observed on surveillance on multiple days. See RX18, RX19, RX22, RX23. Mr. Dennis Burkott, the investigator, testified to the surveillance and noted personal observation of the claimant and authenticated the video. From a layman's perspective the most significant activity was on June 27, 2013, when the claimant was observed tree trimming with a chainsaw (which was presented at trial, weighing about 8 to 15 pounds), as well as gardening and lifting a large plastic tub, and shoveling and lifting plants. The chainsaw started with a left-handed ripcord, which the claimant was shown using on the video with no indication of disablement, pain or limitation of motion. The claimant was further observed on several other days with no apparent dysfunction regarding the left arm.

The claimant testified that he has not worked since the injury. He has applied for SSDI benefits and was granted them, and has been receiving SSDI for at least all of calendar year 2014. He acknowledged looking after his children and working around his house but has not applied or looked for work outside the home. At trial, the petitioner's counsel requested vocational rehabilitation, but did not introduce a vocational report or suggest a particular vocational plan of action.

OPINION AND ORDER RELATIVE TO DISPUTED ISSUES

Causal Relationship to the Injury

There is no dispute that the fall caused the fracture and dislocation, and the medical care to date appears effectively undisputed, though the extent of any remaining physical limitations is shown to have certain discrepancies. The Arbitrator finds that that has more to do with the nature and extent of the petitioner's injuries, however, more than causal connection. The Arbitrator will address this further in each subsection below.

Medical Treatment

As stipulated by the parties, the respondent shall pay any related outstanding medical bills pursuant to Sections 8(a) and 8.2 of the Act. The respondent shall receive credit for any and all amounts previously paid.

No request for any specific medical treatment was presented. As such, the Arbitrator makes no findings as to whether any further medical care would or would not be causally related or reasonably medically necessary, as that would be speculative at this time. The Arbitrator will address vocational rehabilitation in a separate section.

Temporary Total Disability

The claimant submits a request for TTD for the period from September 9, 2010, through the date of trial, October 16, 2014. The respondent concurs that TTD should begin on September 9, 2010, but submits TTD should end on September 8, 2013, when Dr. Walsh examined the claimant. See Arb.Ex.I.

The dispositive question in determining whether a claimant is entitled to TTD is whether his condition has stabilized, i.e., whether he has reached maximum medical improvement (MMI). See, e.g., *Interstate Scaffolding v. Industrial Commission*, 236 Ill.2d 132 (2010). Disability following that point would be characterized as either maintenance or permanent disability, rather than temporary disability. See, e.g., *Archer Daniels Midland v. Industrial Commission*, 138 Ill.2d 107, 118 (1990).

While Dr. Walsh opined that the petitioner was effectively at MMI at the time he examined him on September 8, 2013, he further opined it was medically reasonable to remove the bone stimulator device. As such, the Arbitrator finds MMI would appropriately be assigned to the September 27, 2013 postoperative follow-up appointment with Dr. Gonzalez. While in all likelihood the claimant was able to work at levels far in excess of Dr. Goldberg's assessment by that point, the claimant would likely have been restricted for the week following the surgery, and as such, the Arbitrator finds that TTD eligibility would cease at the MMI date of September 27, 2013, and awards TTD from September 9, 2010 through September 27, 2013, inclusive; any disability following that date would be permanent in nature. Compare *Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission*, supra.

In summary, the claimant has demonstrated eligibility for 1,115 days of TTD as delineated above, or 159 & 2/7 weeks, at the appropriate TTD rate of $1,243.00 per week (statutory maximum rate). This is a total liability of $197,992.14. The respondent is provided credit for $198,702.41 in disability benefits paid to date; the $710.27 in excess disability benefits shall be credited against any further permanent disability award.

Maintenance and Vocational Rehabilitation

While the petitioner did characterize it as TTD on the stipulation sheets, the Arbitrator accepts this as a request for an award of maintenance from September 28, 2013, through the date of trial. The Arbitrator further notes as guidance the cases of *National Tea Co. v. Industrial Commission*, 97 Ill.2d 424 (1983) and *Roper v. Industrial Commission*, 349 Ill.App.3d 500 (5th Dist. 2004).

A claimant can establish maintenance eligibility if engaged in a good faith vocational rehabilitation program, such as a formal counseling program which can include additional training or schooling program, or through a good faith self-directed job search. In this case, the petitioner never sought to pursue either one prior to the hearing date. He admitted never working or seeking any sort of employment since his placement at MMI, instead having sought and received Social Security Disability.

The Arbitrator has reviewed the job duties outlined in RX1, the testimony of the claimant, the medical records and the claimant's behavior and demeanor on covert observation. Given the observed behavior seen on video, the claimant has been shown to have a serious credibility deficit relative to any persistent physical limitation. Furthermore, the claimant has further produced no evidence, be it testimonial or documentary, of any credible attempt at a job search or ongoing educational effort. Nor was there any apparent attempt, prior to the trial date, to seek or request vocational assistance or counseling. This assessment also undermines any claim to maintenance based on a self-directed job search, which has obviously not been undertaken.

The Arbitrator observes that the case of *National Tea Co. v. Industrial Commission*, 97 Ill.2d 424 (1983) notes a lack of motivation is an appropriate factor to consider in determining if any formal vocational maintenance is warranted. Supra at 433, internally citing *Lancaster v. Cooper Industries* (Me. 1978), 387 A.2d 5, 9. Even had his credibility not been lacking, the petitioner's level of action is unacceptable under *National Tea Co.* and *Roper v. Industrial Commission*, supra, and does not meet the requirements to establish a vocational benefit program.

Accordingly, the Arbitrator denies the requests for both maintenance and vocational assistance in their entirety.

CONCLUSION

The Arbitrator finds this matter is presently ready for disposition on the basis of permanent partial disablement. However, as the parties did not place the issue of the nature and extent of the injury before the Arbitrator (see Arb.Ex.I), the Arbitrator makes no findings on such at this time, noting that as this case was heard pursuant to Section 19(b), there is no bar to a subsequent hearing for determination of permanent disability.

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

Rochelle Davenport,

Petitioner,

vs.

NO: 14 WC 01036

University of Illinois,

15IWCC0670

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 temporary total disability, causal connection, medical, prospective medical, penalties and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 19, 2014 is hereby affirmed and adopted.

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

DATED: AUG 25 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:7/9/1/
43

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

DAVENPORT, ROCHELLE
Employee/Petitioner

Case# **14WC001036**

UNIVERSITY OF ILLINOIS
Employer/Respondent

15IWCC0670

On 12/19/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.11% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0579 FRIEDMAN & SOLMOR LTD
GARY B FRIEDMAN
200 N LASALLE ST SUITE 2750
CHICAGO, IL 60601

0075 POWER & CRONIN LTD
JOHN FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

0902 UNIVERSITY OF IL/CLAIMS MGMT
1737 W POLK - M/C 940 SUITE B9
CHICAGO, IL 60612

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

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

DEC 19 2014

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

STATE OF ILLINOIS)
)
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)

Rochelle Davenport
Employee/Petitioner

v.

University of Illinois
Employer/Respondent

Case # 14 WC 01036

Consolidated cases:

15IWCC0670

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Molly Mason**, Arbitrator of the Commission, in the city of **Chicago**, on **November 24, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

15IWCC0670

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

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

On this date, the 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, the Petitioner earned $19,155.76; the average weekly wage was $368.38.

On the date of accident, Petitioner was 45 years of age, *single* with 1 children under 18.

For the reasons set forth in the attached decision, the Arbitrator declines to award the claimed medical expenses.

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

For the reasons set forth in the attached decision, the Arbitrator finds that Petitioner established causation as to the need for the initial Emergency Room visit, a follow-up visit and an orthopedic consultation. The Arbitrator finds that Petitioner failed to prove causation as to her various claimed current conditions of ill-being and as to the treatment provided and recommended by Drs. Yusef, Erickson and Jain.

The Arbitrator finds that Petitioner was temporarily and totally disabled from January 11, 2014 through January 13, 2014, a period of three days. No benefits are payable for this period pursuant to Section 8(b) of the Act.

For the reasons set forth in the attached decision, the Arbitrator declines to award any of the medical expenses claimed by Petitioner. Arb Exh 1. The Arbitrator also declines to award prospective care.

Since no benefits are being awarded, the issue of Respondent's liability for penalties and fees is moot.

Based on the foregoing causation-related finding, the Arbitrator does not include the standard 19(b) remand language in this decision.

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

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

Molly C Mason

Signature of arbitrator

December 18, 2014

Date

DEC 19 2014

Rochelle Davenport v. UIC
14 WC 1036

15IWCC0670

Arbitrator's Findings of Fact

Petitioner testified she began working as a building service worker for Respondent in 2007. She worked in a student dormitory, mopping, vacuuming, making beds and disposing of garbage. She typically worked from 1:30 PM until 9:30 or 10:30 PM.

There is no dispute that Petitioner sustained an accident at work on January 10, 2014. Arb Exh 1. Petitioner denied injuring her neck or back or undergoing any neck or back treatment during the seven years she worked for Respondent before this accident.

Petitioner testified that, at 8:17 PM on January 10, 2014, she entered an elevator on the fifth floor and descended to the second floor. A co-worker named Michael got out of the elevator ahead of her once the elevator reached the second floor. She was unsure of Michael's last name. She then began to exit, pushing a garbage container in front of her. As she crossed the threshold, the elevator doors "slammed" closed on her.

Under cross-examination, Petitioner clarified that the garbage container had already cleared the elevator when the elevator doors slammed shut. At that point, she was extending both of her arms in front of her, while maintaining contact with the container. When the doors closed, they came into contact with the outside of her upper arms. She could not say that the doors struck her neck but her neck hurt after the doors closed. She was standing still, facing forward, during the time the doors remained closed. When the doors opened, she went down to the lobby, using another elevator.

Respondent offered into evidence a video of the accident (RX 2) as well as additional video (RX 3) taken on the day of the accident. The parties viewed the videos during the hearing. Petitioner did not object to the admission of the videos. The footage on RX 2 came from a security camera located in the rear of the elevator. The footage shows Petitioner (from the rear) beginning to exit the elevator, while pushing the cart ahead of her. As Petitioner reaches the threshold, both elevator doors move inward and make contact with the outsides of Petitioner's upper arms. The doors remain in contact with Petitioner's arms for about ten seconds. Petitioner remains standing, facing forward, during this time. Her body position does not change. During that ten-second period, a person's hand can be seen reaching into the elevator from outside. The doors then open. After the doors open, Petitioner can be seen exiting the elevator, briefly standing outside the elevator and then resuming pushing the cart, in the presence of a male individual. As for Petitioner's clothing, the Arbitrator was only able to discern that Petitioner is wearing a long-sleeved garment.

On direct examination, Petitioner testified she experienced significant pain in her right side, from her neck to her low back, after the accident. When she reached the lobby, she went to the guard desk. A student was manning the desk. No manager was on duty because it was

night time. She told the student about the accident and he called an ambulance. After the ambulance arrived, paramedics took her to the Emergency Room at Stroger Hospital.

Petitioner testified she provided Emergency Room personnel with a history of the accident and complained of pain in her right side, neck and lower back. Petitioner further testified that the providers at the Emergency Room prescribed medication and instructed her to stay off work and seek follow-up care.

Petitioner offered five pages of Stroger Hospital Emergency Room records into evidence. One of those pages reflects that Petitioner went to the Emergency Room at 10:04 PM on January 10, 2014 and was diagnosed with "musculoskeletal chest pain." Other pages reflect that a physician named Dr. Lew prescribed Ibuprofen and directed Petitioner to stay off work for three days and see her personal care physician within one to two days. None of the pages complaints other than "musculoskeletal chest pain" or examination findings. PX 1.

While no other Emergency Room records are in evidence, the Arbitrator notes that Respondent's Section 12 examiner, Dr. Butler, referenced such records in his report and during his deposition. Dr. Butler testified that the Emergency Room records documented a history of Petitioner pushing a cart into or out of an elevator when the elevator "locked," causing the doors to close on her and "push on" her right chest and back. In his report, he indicated that the history set forth in the records described Petitioner as being trapped between the elevator doors until someone forced the doors open. Dr. Butler testified that the records documented examination findings of "tenderness to palpation of the right chest and upper back along the scapula." RX 1 at 8-9.

Under cross-examination, Petitioner denied that she resumed working during the interval between the accident and the arrival of the ambulance. Petitioner also denied being diagnosed with a chest contusion. At the Emergency Room, she was experiencing swelling in her right side and red, burn-like marks below her armpits. She indicated she did see her personal care physician [who is identified as Dr. Sodade in various treatment records] in follow-up, per the instructions she received at the Emergency Room, but no records from this physician are in evidence.

Petitioner testified she experienced pain in her right side, as well as burning and "tremendous" pain in her neck and lower back, between January 10 and 13, 2014. She found it difficult to move around during that period.

Petitioner retained counsel on January 13, 2014 and filed an Application the following day, alleging she injured her right side, neck, shoulder and back on January 10, 2014 when elevator doors closed on her while she was moving a large container of trash.

On January 13, 2014, Petitioner saw Dr. Yusef, a chiropractor affiliated with Serenity Chiropractic. Petitioner testified she was referred to Dr. Yusef by her nephew's relative.

An information sheet in the doctor's chart reflects that Petitioner complained of 10/10 pain in her entire right side, aggravated by movement.

Handwritten treatment notes and a lengthy form dated January 13, 2014 reflect that Petitioner complained of dizziness, difficulty walking and pain in multiple body parts, including the right side of her head, the right arm and scapular area, the right wrist and forearm, the upper, mid and low back, the pelvis, the right leg, the right knee, the right ankle and the right foot. One note reflects that Petitioner attributed her complaints to getting stuck in an elevator and door. The notes also reflect that Petitioner was taking Ibuprofen but not finding it helpful. On examination, Dr. Yusef noted swelling of the right foot and tenderness in the cervical paraspinals, levator scapular area, trapezius, thoracic paraspinals and lumbar paraspinals. She indicated that all of Petitioner's pain was "on the right side." She diagnosed severe myalgia, cervical radiculitis and pelvic unleveling. She took Petitioner off work and recommended chiropractic care, consisting of adjustments, traction and electric muscle stimulation, three times weekly. PX 2.

Under cross-examination, Petitioner acknowledged complaining to Dr. Yusef of severe pain in her right side, from the neck down. She denied complaining of headaches, dizziness or ankle pain.

Petitioner testified she continued undergoing treatment with Dr. Yusef until April 23, 2014. The treatment consisted of lying on a table, while undergoing roller massages and applications of ice, heat and electric stimulation.

Dr. Yusef's handwritten notes reflect that Petitioner complained of a "new symptom in her R calf muscle" on January 15, 2014. PX 2.

According to Respondent's examiner, Dr. Butler, Petitioner saw a nurse practitioner named "Zahakaylo" on January 16, 2014 "with complaints of right-sided neck pain, right chest wall pain, right abdomen pain and right lower back pain." Dr. Butler indicated that "Zahakaylo" assessed Petitioner as having "multiple contusions, crush injury with neck pain, lateral chest wall, abdomen and lower back pain." Dr. Butler also indicated that "Zahakaylo" advised Petitioner to "continue with Motrin and follow up with orthopedics." On the second page of his report, Dr. Butler clarified that "Zahakaylo's" care took place at University Health Service. Butler Dep Exh 2, pp. 1-2. No treatment note dated January 16, 2014 is in evidence.

According to Dr. Yusef, Petitioner started physical therapy on February 3, 2014 and complained of soreness the following day. On February 6, 2014, Dr. Yusef described Petitioner as "improving as expected." On February 12, 2014, the doctor indicated she anticipated Petitioner would remain totally disabled through March 3, 2014. PX 2.

On February 21, 2014, Petitioner saw Dr. Erickson, a neurosurgeon associated with Michigan Avenue Medical Associates. Dr. Erickson noted a past history of an ankle fracture in 2003 and foot surgery. He also noted that Petitioner reported an immediate onset of severe

right-sided ribcage, neck, shoulder and low back pain on January 10, 2014, when she was caught between two elevator doors that shut suddenly.

Dr. Erickson stated that Petitioner was still experiencing low back pain, rated 10/10, and right shoulder pain, rated 7/10. He also indicated Petitioner "described paresthesia radiating to the fifth toe on the right side."

Dr. Erickson described his most significant examination finding as that of poor gastroc strength on the right side. He indicated Petitioner was unable to raise the toes of her right foot.

Dr. Erickson diagnosed low back pain with radiculopathy affecting the right lower extremity. He ordered a lumbar spine MRI scan and attributed the need for this scan to the work accident. He also prescribed Hydrocodone. PX 6. He instructed Petitioner to stay off work and continue therapy with Dr. Yusef. He wrote out a slip prescribing therapy "to address LBP and R shoulder pain." PX 4.

Dr. Yusef continued treating Petitioner thereafter. Her notes after February 21, 2014 document complaints of activity-related back pain and very occasional complaints relative to the right shoulder and neck.

On March 10, 2014, Dr. Yusef noted that Petitioner complained of right knee pain that had started over the preceding weekend.

On March 19, 2014, Dr. Yusef noted complaints of moderate neck and right shoulder pain and severe, 10/10 pain in the lower back. PX 2.

According to various records in evidence, Petitioner underwent a CT scan of the head at South Suburban Hospital on March 20, 2014, per her personal care physician. The scan report is not in evidence.

On March 25, 2014, Petitioner underwent a lumbar spine CT scan per Dr. Yusef. The scan showed mild disc bulging in the lower lumbar spine with no definitive focal disc herniation or significant stenosis and mild degenerative changes of both sacroiliac joints. The radiologist described the evaluation of the L5-S1 disc level central canal as "sub-optimal." PX 7.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Butler on March 26, 2014.

Petitioner testified that Dr. Butler did not ask where her pain was located. Dr. Butler tested her knee reflexes but did not press on her body or test her range of motion.

In his report of March 26, 2014, Dr. Butler indicated he reviewed records from the following providers: Stroger Hospital, Dr. Yusef, "APN/CNP Zahakaylo" and Dr. Erickson. He also indicated he reviewed a head CT scan report, with the scan described as unremarkable.

Dr. Butler noted a past history of right ankle surgery in 2003.

Dr. Butler noted that Petitioner's current medications included Ibuprofen and Norco.

Dr. Butler noted no strength or sensory abnormalities on neurologic examination. On musculoskeletal examination, he noted moderate tenderness in the lumbar spine, a positive Waddell's sign (diminished pain on distraction) and negative straight leg raising. With respect to range of motion testing, he noted that Petitioner "refused to bend in any plane."

Dr. Butler noted that he reviewed surveillance video of the actual incident. He indicated that the video showed the elevator doors contacting Petitioner's shoulders and arms but not compressing her lower back in any fashion. He also indicated Petitioner was "wearing a heavy padded coat" at the time of the incident.

Dr. Butler opined that Petitioner "did not sustain any injury to her lumbar spine as a result of the work incident in question." He described Petitioner's current complaints as "fictitious in nature." He indicated that the treatment to date "has not been reasonable or necessary as it relates to the work injury." He saw "no medical indication whatsoever to obtain an MRI scan of the lumbar spine or chiropractic care for this complaint of pain." He found Petitioner capable of full duty. Butler Dep Exh 2.

On April 1, 2014, Petitioner returned to Michigan Avenue Medical Associates and saw Dr. Jain, a pain management physician. A form in the doctor's chart reflects that Petitioner described her January 10, 2014 work accident as follows:

> "I was exiting an elevator that slammed me on both sides of my body pending [sic] me tight and the only way to get out someone had to force the doors open."

The same form reflects that Petitioner complained of pain in her head, neck and lower back as well as difficulty sleeping, anxiety, depression, memory loss, loss of balance, cold feet and tingling in her right hand.

Dr. Jain recorded the following history of the work accident and subsequent care:

> "The patient was exiting an elevator and got caught between elevator doors that shut unexpectedly and suddenly. She had immediate onset of head and neck pain, right shoulder pain, right chest wall pain, knee pain and low back pain. The patient stated that she was trapped within the doors and someone had to force the doors open to release her. She was taken to the health services at UIC and X-rays were done. She continued to have pain and stiffness in her head, neck, shoulder, ribcage and

low back. Pain has remained moderate to severe since the injury."

Dr. Jain also described Petitioner as having "significant right knee pain that makes it difficult to walk" along with numbness in the right foot and fifth toe, headaches and blurry vision. He noted that Petitioner had recently undergone a head CT scan per Dr. Sowade. [No records concerning this scan are in evidence.] He also noted that Petitioner was "intolerant" of MRI scans and had recently undergone a lumbar spine CT scan. He interpreted this scan as showing a disc herniation at L5-S1.

Dr. Jain described Petitioner's gait as severely antalgic. On lumbar spine examination, he noted severe pain with palpation bilaterally at the lumbosacral junction, a very limited range of motion, positive straight leg raising on the right, with some decrease in right foot dorsiflexion, reduced right pinprick on the L5 distribution and no positive Waddell's signs. On right knee examination, he noted swelling in the infrapatellar area and pain with extension and flexion. On cervical spine examination, he noted significant spasm in the right trapezius and rhomboid.

Dr. Jain indicated that Petitioner's pain appeared to be "more facetogenic than radicular." He recommended SSEP testing of the lower extremity to further delineate the nature of the radiculopathy, given that no MRI was done. He also recommended bilateral facet injections at L3-L4, L4-L5 and L5-S1, cervical spine and right knee CT scans, an orthopedic evaluation with Dr. Schafer for the right knee, continued therapy with Dr. Yusef and medication (Mobic, Flexeril and Prilosec). He indicated that Petitioner should remain off work pending an orthopedic evaluation by Dr. Schafer on April 9th [no records from Dr. Schafer are in evidence] and a return visit to him on May 1st. He opined that the work accident aggravated an underlying but previously asymptomatic degenerative condition.

Under cross-examination, Petitioner testified she had no recollection of complaining of knee pain, headaches or numbness in her right hand or right toes when she saw Dr. Jain.

The cervical spine CT scan, performed on April 7, 2014, showed no acute abnormality and early spondylosis of C5-C6. The right knee CT scan, performed the same day, showed no acute abnormalities and "advanced patellofemoral osteoarthritis with subcortical cysts on both sides of the joint, more so on the patella, and patellofemoral spurs." PX 7.

Petitioner returned to Dr. Jain on April 17, 2014. The doctor described Petitioner as essentially unchanged. He noted she was still experiencing severe pain in her neck, back and right knee. He described the neck pain as radiating to the left arm, with numbness in the small finger. [In a separate history form, Petitioner complained of tingling in her right hand.]

Dr. Jain noted that Petitioner reporting seeing Dr. Butler on March 26th but indicated that the doctor "never directly examined her or actually touched her." Dr. Jain described Dr. Butler's IME report as "somewhat rambling" and indicated that Dr. Butler's "IMEs are almost identical for every patient, denying causation and further care." He described Dr. Butler as

reviewing a video and drawing conclusions "that are entirely beyond the scope of his expertise in terms of the compression of the elevator doors on the patient." He disagreed with Dr. Butler's statement that Petitioner is "objectively normal," given Petitioner's current right knee pain, very limited neck and back range of motion and left C7 radiculopathy.

Dr. Jain recommended both cervical and lumbar facet injections. He again recommended SSEP testing of the lower extremity, an orthopedic evaluation of the right knee and continued therapy. He instructed Petitioner to remain off work. He noted that Petitioner was scheduled to see Dr. Schafer for an orthopedic evaluation on April 23, 2014. PX 4.

On April 23, 2014, Dr. Yusef recommended a back brace and referred Petitioner to Dr. Harvey. [No records from Dr. Harvey are in evidence. After April 23, 2014, Dr. Yusef did not see Petitioner again until July 29, 2014.] PX 2.

The next treatment note in evidence is Dr. Herba's SSEP test report dated June 27, 2014. The doctor described the test results as consistent with S1 lumbar radiculopathy. PX 4.

Petitioner also saw Dr. Erickson on June 27, 2014. Dr. Erickson noted that Petitioner was still experiencing pain in her neck, low back and right knee but described her neck pain as somewhat improved.

On examination, Dr. Erickson again noted weakness of the gastroc muscle and localized right knee pain and mild swelling. On range of motion testing of the right knee, he noted an audible click. He refilled Petitioner's pain medications and recommended a lumbar spine MRI, to be performed in an open unit. He attributed the need for the MRI to the work accident. On a separate form, he indicated that cervical and lumbar injections were pending but that Petitioner could resume full duty as of June 30, 2014. PX 4.

Petitioner returned to Dr. Yusef on July 29, 2014, having last seen the doctor on April 23, 2014. In her note of July 29, 2014, Dr. Yusef indicated that Petitioner complained of 4-5/10 right arm pain and 10/10 low back pain. She referenced a letter. Attached to the July 29, 2014 note is a handwritten letter from Petitioner dated July 29, 2014 indicating she called both Dr. Yusef and Dr. Erickson that morning and asked to be seen due to severe low back pain. In the letter, Petitioner indicated that the doctors had previously released her at her request because she was "broke" and had bills to pay. She also indicated she was still in pain and could not tolerate her pain any longer. She indicated she was scheduled to see Dr. Yusef that day and Dr. Erickson on July 31, 2014. [No July 31, 2014 note from Dr. Erickson is in evidence.] PX 2.

On October 23, 2014, Petitioner filed a 19(b) petition along with a petition for penalties and fees. The 19(b) petition lists two providers: Stroger Hospital and Dr. Holly Carobene. No records from Dr. Carobene are in evidence. It appears that Petitioner previously filed similar petitions since Respondent filed a response to motion for penalties on March 4, 2014 (RX 5) and a 19(b) response on May 14, 2014 (RX 4).

Petitioner testified she has not undergone the recommended injections due to lack of authorization. As of her June 27, 2014 visit to Dr. Erickson, her neck had improved but she was still experiencing right-sided back pain. At that visit, Dr. Erickson gave her written restrictions. She returned to work on June 30, 2014 and gave the restrictions to "Trin," a nurse practitioner in Respondent's medical unit. Between late January and June 30, 2014 she made weekly visits to "Trin." She also saw her supervisor, John. [This supervisor, John Bruch, attended the hearing but did not testify.] John told her no work was available. She has returned to Respondent's human resources department eight or nine times since June 30, 2014 but has not returned to work. She has also gone to Respondent's medical department.

Petitioner testified she is still experiencing right-sided lower back pain. The pain makes it difficult to get out of bed. She has medication but it does not help. The pain shoots up and down her right side and her back gives out on her. Extended sitting bothers her, as does cooking. She wants to undergo the injections.

Under cross-examination, Petitioner testified that Dr. Erickson provided her with written work restrictions on June 27, 2014. She denied that the doctor released her to full duty on that date. The full duty release that appears in PX 4 is not the slip she presented to "Trin." Respondent did not explain why no work was available. Respondent categorized her job as "extra help." She was to work 900 hours and then get called back as needed. She is not sure whether she has returned to Dr. Erickson since June 27, 2014. She is unsure about dates.

On redirect, Petitioner testified she complained of 6/10 low back pain to Dr. Erickson on June 27, 2014. She never received a slip from Dr. Erickson releasing her to full duty. She was still awaiting injections on June 27, 2014. On that date, she asked Dr. Erickson to release her to restricted duty because she needed money. The doctor agreed. After seeing Dr. Erickson on June 27, 2014, she presented paperwork to "Trin"" and her supervisor. She has received no benefits to date. Respondent has not taken her back to work. She has not returned to a doctor because she does not have the money to pay for care. She has not sustained any new injuries since January 10, 2014. She would resume care if the Arbitrator awarded the recommended injections.

In addition to the exhibits previously described, Petitioner offered into evidence bills from Dr. Yusef, Michigan Avenue Medical Associates and Skan National Radiology Services along with prescription bills from IWP and EqMed. Respondent offered into evidence Dr. Butler's deposition testimony of May 21 and July 2, 2014.

On May 21, 2014, Dr. Butler testified he is a fellowship-trained spine surgeon. He is board certified in orthopedic surgery and independent medical examinations. RX 1 at 5. He specializes in adult spine surgery. About 25% of the people he sees are "work-related injuries and independent medical exams." RX 1 at 6.

Dr. Butler testified he examined Petitioner on March 26, 2014. He reviewed various records in connection with his examination. Specifically, he reviewed treatment records from

Stroger Hospital, Dr. Yusef, Dr. Erickson, UIC Occupational and South Suburban Hospital, where Petitioner underwent a brain CT scan. RX 1 at 8. The complaints Petitioner voiced at Stroger's Emergency Room were specific, i.e., tenderness to palpation of the right chest and upper back, but the complaints she voiced to Dr. Yusef three days later were "very diffuse." RX 1 at 9-10. When Petitioner saw a nurse at Respondent's occupational health facility on January 16, 2014, the nurse noted complaints of right-sided neck pain, chest wall pain, abdominal pain and lower back pain. RX 1 at 10. Dr. Yusef referred Petitioner to Dr. Carobene, a pain specialist, but he did not review any records from Dr. Carobene. RX 1 at 10. When Dr. Erickson first saw Petitioner, he noted a complaint of paresthesia radiating to the fifth toe on the right side. That complaint could be consistent with an S1 radiculopathy. RX 1 at 11-12.

Dr. Butler testified he watched some security videos well after he examined Petitioner. Some footage he watched showed an elevator door closing on Petitioner's shoulders and the "meaty part of her tricep." Petitioner was wearing a heavy coat and "seemed to just stand there while the doors were closed." The doors opened a short time thereafter. RX 1 at 13.

Dr. Butler testified that the videos he watched contributed to his opinions. Petitioner's verbal description of the accident was more vivid than the accident footage he viewed. RX 1 at 14.

Dr. Butler testified that, when he met with Petitioner, Petitioner showed him various photographs she had taken with her cell phone. The photographs were of a loading dock and garbage dumpsters. Petitioner told him her fellow employees did not work hard and she had to make up for their lack of effort.

Dr. Butler testified that, at his request, Petitioner completed an Oswestry Disability Index form. Petitioner's responses on this form showed that she perceives herself as severely disabled. RX 1 at 16-17. Petitioner indicated she could only lift very light weights and needed help every day with most aspects of self care. RX 1 at 19.

Dr. Butler testified he obtained Petitioner's vital signs. As of the examination, Petitioner was 5 feet, 8 inches tall and weighed 298 pounds. RX 1 at 20. Petitioner falls into the morbidly obese category. RX 1 at 20. Petitioner's gait was normal, as was her lower extremity neurological examination. Petitioner complained of moderate tenderness to palpation of the lumbar spine. RX 1 at 20. He asked Petitioner to bend so that he could determine her range of motion but she refused to bend at all due to complaints of pain. RX 1 at 22. He noted a positive Waddell's finding, i.e., diminished pain on distraction. Petitioner "seemed to move about relatively freely until it came time for the exam." RX 1 at 22. With distraction and conversation, Petitioner's pain behavior was "very minimal." RX 1 at 23. Straight leg raising was negative.

Dr. Butler testified that, based on his video and records review, as well as his examination findings, he did not believe the elevator door incident resulted in any spinal injury. He noted no finding that was consistent with an S1 nerve root injury. RX 1 at 23-24. The

impact shown on the video was to both shoulders and the posterior aspect of both arms. He could understand that the impact could have caused some shoulder or chest discomfort but he sees "no anatomic basis" for a neck or lower back injury. RX 1 at 25. He does not believe Petitioner requires any additional treatment for her spine. The lumbar spine MRI that Dr. Erickson recommended was not reasonable or necessary. RX 1 at 28. Relative to the spine, Petitioner could perform regular duty. RX 1 at 30. None of his own examination findings correlated with Dr. Jain's finding of pain radiating to the left arm with numbness into the small finger. RX 1 at 31.

Dr. Butler testified that the information Dr. Jain recorded, i.e., that he (Dr. Butler) never touched Petitioner during his examination, is "absolutely false." RX 1 at 33. Also false is Dr. Jain's comment that all of his (Dr. Butler's) reports are the same. Dr. Butler testified that, in response to this comment, he reviewed twenty consecutive examinations he conducted in March. He found causation in nineteen of these twenty and recommended additional care in seven of the twenty. RX 1 at 34. Dr. Jain's statement about his (Dr. Butler's) lack of expertise in video interpretation has no factual basis. The ability to look at an accident video and draw conclusions from that video is fundamental to what physicians do every day. RX 1 at 35.

[At this point in the deposition, Petitioner's counsel requested a continuance so as to obtain the twenty examination reports Dr. Butler referenced on direct examination.]

Under cross-examination, on July 2, 2014, Dr. Butler testified he has performed close to 600 independent medical examinations per year during the last two to three years. RX 1 at 41. He used to charge $1200 per examination (including record review) and now charges $1500. RX 1 at 42. He charges $2000 for two hours of deposition time. RX 1 at 43. Of the approximate 600 examinations he performs annually, over 90% are for respondents or carriers. RX 1 at 43. Almost all of the examinations involve work injuries. RX 1 at 43. He has an independent recollection of Petitioner. Petitioner was very large and very charismatic. She showed him workplace pictures on her cell phone. RX 1 at 45. He is familiar with the buildings Petitioner described. RX 1 at 45-46. The physical part of his examination took five to ten minutes. RX 1 at 46. All of his findings were normal. RX 1 at 46. He asked Petitioner to bend but she flatly refused. RX 1 at 47. She told him she was not going to do that. RX 1 at 47. Range of motion testing is voluntary, in his view. If someone refuses to bend, he cannot assess range of motion. RX 1 at 47. He was not going to push Petitioner into bending. RX 1 at 49. There seemed to be a disconnect between Petitioner's high pain rating and perceived disability score and the "dynamic, very personable nature" of his interaction with Petitioner. RX 1 at 50. The only positive Waddell's finding he noted was diminished pain on distraction. RX 1 at 51-52. He knows of Dr. Jain professionally but is not personally acquainted with him. RX 1 at 55. He was not present when Dr. Jain examined Petitioner. The findings Dr. Jain noted were not present when he examined Petitioner. RX 1 at 56. It is possible for someone like Petitioner to have good days. RX 1 at 56. Of the examination reports he examined, after reading Dr. Jain's comment, he recommended in five cases that an individual stay off work. In those five cases, disc herniations were present. He also recommended that other individuals who had

herniations return to work. RX 1 at 60. He found causation in seventeen of the cases. RX 1 at 61.

On redirect, Dr. Butler testified that he does not know how Dr. Jain conducts range of motion testing. With active range of motion testing, there is a subjective component. RX 1 at 65. Dr. Erickson did not include range of motion testing in his February 21, 2014 note. RX 1 at 67. Dr. Jain's range of motion results do not prompt him to change his opinion that Petitioner did not injure her lumbar spine. RX 1 at 67. Petitioner had "strong subjective complaints throughout the entire course of her care." RX 1 at 67-68.

Preliminary Comment

As noted in the foregoing findings of fact, a number of treatment records are not in evidence. The Arbitrator would have found it helpful to review the complete Emergency Room records, the University Health Service note of January 16, 2014 (and any subsequent University Health Service records), the records of Dr. Sodade (Petitioner's personal care physician) and the head CT scan report. Petitioner testified that Dr. Erickson issued written work restrictions on June 27, 2014. No such restrictions are in evidence. Dr. Erickson's records reflect that, on June 27, 2014, he released Petitioner to full duty while noting that previously recommended cervical and lumbar injections were "pending authorization." PX 4. If, in fact, Petitioner returned to Dr. Erickson on July 31, 2014, as Dr. Yusef noted when she saw Petitioner on July 29th, it would have been helpful for the Arbitrator to read what Dr. Erickson had to say on that date.

Arbitrator's Credibility Assessment

Petitioner was prone to hyperbole.

Petitioner was less than credible on several issues. Under cross-examination, she disagreed with a number of her treatment records. She denied complaining of headaches and dizziness to Dr. Yusef. She denied reporting improvement to Dr. Yusef in February. She had no recollection of complaining to Dr. Jain of headaches, knee pain and right hand/toe numbness and tingling. Her attempt to distance herself from the knee complaints is at odds with her claim for a right knee CT scan bill. PX 8.

The Arbitrator finds credible Petitioner's testimony that she made various visits to, and tendered paperwork at, a health facility operated by Respondent. Petitioner's testimony on this point is supported by Dr. Butler's reference to a University Health Service note of January 16, 2014. Dr. Butler indicated that the provider who saw Petitioner on that date prescribed Motrin and recommended an orthopedic consultation.

Dr. Butler noted a positive Waddell's sign and went so far as to describe Petitioner's complaints as "fictitious." Drs. Jain and Erickson did not note positive Waddell's signs.

Did Petitioner establish a causal connection between her undisputed accident and her various claimed current conditions of ill-being?

The Arbitrator, having viewed Respondent's videos (RX 2 and 3) and considered Petitioner's testimony along with the available records, finds that Petitioner established causation as to contusions and right-sided chest and upper back pain that merited Emergency Room evaluation, a follow-up visit to her own physician (with Petitioner making that visit, according to her testimony, but not providing the records to the Arbitrator) and an orthopedic consultation, which was apparently recommended by Respondent's own medical facility on January 16, 2014 but not performed at that time. It appears that the only orthopod who evaluated Petitioner was Respondent's examiner, Dr. Butler. As indicated above, Dr. Butler noted no objective abnormalities and recommended no care.

The Arbitrator finds that Petitioner failed to establish causation as to the need for the treatment provided and recommended by Drs. Yusef, Erickson and Jain. These doctors relied solely on Petitioner's description of the mechanism of injury. There is no evidence indicating they saw the accident video. Moreover, they based some of their treatment and work recommendations on complaints that Petitioner denied making. Dr. Yusef noted complaints of dizziness and pain in multiple body parts when she first examined Petitioner. Petitioner disputed the accuracy of Dr. Yusef's notes and denied making several of the recorded complaints. Dr. Erickson noted right foot complaints when he first examined Petitioner but, again, Petitioner denied making any such complaints. Drs. Jain and Erickson later noted right knee abnormalities but Petitioner does not claim to have injured her right knee in the accident. Dr. Jain assumed that the elevator doors "slammed" onto Petitioner, that Petitioner remained "trapped" afterward and that Petitioner experienced an immediate onset of pain in various body parts, including her head and low back. The accuracy of those assumptions is called into question by RX 2 and the available information concerning the initial Emergency Room complaints and findings.

Is Petitioner entitled to temporary total disability benefits?

Petitioner claims she was temporarily totally disabled from January 11, 2014 through the hearing of November 24, 2014. Arb Exh 1.

Based on the foregoing causation-related findings, as well as the limited Emergency Room records in PX 1 and Dr. Butler's summary of the Emergency Room records he reviewed, the Arbitrator finds that Petitioner was temporarily totally disabled for three days. The records in PX 1 show that Dr. Lew directed Petitioner to stay off work for that period of time. The Arbitrator awards no temporary total disability benefits because Section 8(b) of the Act does not allow for an award of benefits during the first three days off work.

Is Petitioner entitled to reasonable and necessary medical expenses? Is Petitioner entitled to prospective care?

Based on the foregoing causation-related findings, the Arbitrator would have awarded the Emergency Room bill and the bill relating to Petitioner's follow-up visit to Dr. Sodade but. Petitioner did not claim either of these bills. The Arbitrator declines to award the bills claimed by Petitioner. Those bills are listed on the Request for Hearing form. Arb Exh 1.

Based on the foregoing causation-related findings, the Arbitrator denies Petitioner's claim for prospective care in the form of cervical and lumbar injections.

Is Respondent liable for penalties and fees?

The Arbitrator awards no penalties or fees in this case. The Arbitrator has not awarded any temporary total disability benefits or medical expenses on which penalties and/or fees could be assessed.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Jerry Clark,
Petitioner,
vs.
City of Chicago,
Respondent,

NO: 10 WC 06278

15IWCC0671

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 temporary total disability, permanent partial disability, medical, causal connection and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 27, 2014 is hereby affirmed and adopted.

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

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

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

DATED: AUG 25 2015

Mario Basurto

David L. Gore

Stephen Mathis

MB/mam
o:7/9/15
43

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CLARK, JERRY
Employee/Petitioner

Case# **10WC006278**

15IWCC0671

CITY OF CHICAGO
Employer/Respondent

On 1/27/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.06% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1067 ANKIN LAW OFFICE LLC
SCOTT GOLDSTEIN
162 W GRAND AVE
CHICAGO, IL 60654

0766 HENNESSY & ROACH PC
NATALIE ROMO
140 S DEARBORN 7TH FL
CHICAGO, IL 60603

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

STATE OF ILLINOIS)
)
COUNTY OF COOK)

ILLINOIS WORKERS' COMPENSATION COMMISSION

ARBITRATION DECISION

JERRY CLARK
Employee/Petitioner

Case #10 WC 6278

v.

15IWCC0671

CITY OF CHICAGO
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 Robert Williams, arbitrator of the Workers' Compensation Commission, in the city of Chicago, on January 15, 2014. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☐ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On February 10, 2010, the respondent was operating under and subject to the provisions of the Act.

- On this date, an employee-employer relationship existed between the petitioner and respondent.

- On this date, the petitioner sustained injuries that arose out of and in the course of employment.

- Timely notice of this accident was given to the respondent.

- In the year preceding the injury, the petitioner earned $68,536.00; the average weekly wage was $1,318.00.

- At the time of injury, the petitioner was 53 years of age, single with two children under 18.

- The parties agreed that the respondent paid $30,876.11 in temporary total disability benefits.

- The parties agreed that the petitioner is entitled to temporary total disability benefits of $878.67/week for 35-2/7 weeks from February 11, 2010, through October 15, 2010.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $878.67/week for 36-6/7 weeks, from February 11, 2010, through October 26, 2010, which is the period of temporary total disability for which compensation is payable.

- The respondent shall pay the petitioner the sum of $664.72/week for a further period of 50 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 10% loss of use of the man as a whole.

- The respondent shall pay the petitioner compensation that has accrued from February 10, 2010, through January 15, 2014, and shall pay the remainder of the award, if any, in weekly payments.

- The costs for the EMG/NCV study on November 3, 2010, the Soma prescriptions in October 2010, the caudal epidural steroid injections on August 13, 2010, and October 15, 2010, and the FCE on January 24, 2011, are denied. The remaining medical care rendered the petitioner was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act and the medical fee schedule. The respondent shall be given credit for any amount it paid toward the medical bills, including any amount paid within the provisions of Section 8(j) of the Act, and any adjustments, and shall hold the petitioner harmless for all the medical bills paid by its group health insurance carrier.

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

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

Robert E. Williams

Signature of Arbitrator

January 24, 2014

Date

JAN 27 2014

FINDINGS OF FACTS: 15IWCC0671

The petitioner, a motor truck driver, slipped on ice and fell on February 10, 2010. He received emergency care at Resurrection Health Care, where he reported slipping and striking his right ribs. He was treated for a right rib contusion. X-rays of his right rib cage revealed a non-displaced fracture of the tenth rib. He received care the next day at MercyWorks, where he reported injuries to his right rib cage, lower and center back, right shoulder, left leg and right hand. The treatment prescribed was medications, icing and a back brace. The petitioner reported severe lateral chest pain and moderate back pain on February 16th. At his last follow-up at MercyWorks, the petitioner complained of severe right chest pain and low back pain radiating to his posterior left thigh.

According to billing records in evidence, the petitioner started care with Dr. Foreman of Northside Medical Center on February 16th; however, their treating records are not in evidence. An MRI on March 12th revealed disc bulging and hypertrophy of the posterior elements at multiple levels and minimal spinal canal stenosis and bilateral neural foraminal stenosis in the inferior portions. The petitioner received physical therapy and other conservative modalities with Dr. Foreman through May 26th. At the request of the respondent, Dr. Kern Singh evaluated the petitioner on April 19th and opined that the petitioner had degenerative disc disease at L4/5 and was magnifying his symptoms.

The petitioner started care with Dr. Malek on July 23rd for neck and mid and low back pain. A straight-leg raising test was positive on the left side. At the request of the respondent, Dr. Kern Singh re-evaluated the petitioner on July 29th and re-stated his finding of degenerative disc disease at L4/5. Dr. Malek gave the petitioner caudal transforaminal epidural steroid injections on the left at L3-4 and L4-5 on July 30th,

August 13th and October 15th that provided partial response. At a third evaluation by Dr. Singh on September 30th, the petitioner reported that his lower back pain had improved and he had no lower extremity radiculopathy or dysesthesias. Dr. Malek opined on October 29th that a discography performed by him confirmed the pain generators are at the L3/4 and L4/5 levels. A CT scan of his lumbar spine on October 29th revealed abnormal discs at L3/4, L4/5 and L5-S1.

An EMG/NCV study on November 3rd revealed chronic bilateral lumbar neuropathy involving L4 through S1 nerve roots. An MRI on December 17th revealed a 3 mm protrusion at L4/5, multilevel annular and neural foraminal disc bulging with neural foraminal stenosis and mild dextroconvex and lumbar spondylosis. A functional capacity evaluation on January 24, 2011, demonstrated the petitioner's functional capabilities at the medium physical demand level. On February 11th, the petitioner reported to Dr. Malek that his symptoms had worsened.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

Utilization reviews of the EMG/NCV study on November 3, 2010, the Soma prescriptions in October 2010, the caudal epidural steroid injections on August 13, 2010, and October 15, 2010, and the FCE on January 24, 2011, were not certified. Their costs are denied. The remaining medical care rendered the petitioner was reasonable and necessary and is awarded.

REGARDING WHETHER THE PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY:

Based upon the testimony and the evidence submitted, the petitioner proved that his current condition of ill-being with his low back and right tenth rib is partially causally related to the work injury.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

As a result of his injury, the petitioner received work restrictions and was off of work through October 27, 2010. The respondent shall pay the petitioner temporary total disability benefits of $878.67/week for 36-6/7 weeks, from February 11, 2010, through October 26, 2010, as provided in Section 8(b) of the Act, because the injuries sustained caused the disabling condition of the petitioner.

FINDING REGARDING THE NATURE AND EXTENT OF INJURY:

The petitioner has degenerative disc disease at L4/5. He currently complains of daily, 24-hour back pain. He uses medication and deals with the back pain. The respondent shall pay the petitioner the sum of $664.72/week for a further period of 50 weeks, as provided in Section 8(d)2 of the Act, because the injuries sustained caused the permanent partial disability to petitioner to the extent of 10% loss of use of the man as a whole.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lisa Richmond,
Petitioner,

vs. No. 14 WC 01857

Cambridge House of Maryville,
Respondent.

15IWCC0672

DECISION AND OPINION ON REVIEW

A Petition for Review having been timely filed by Petitioner and notice given to all parties, the Commission, after considering the issues of accident, causal connection, medical expenses, temporary total disability benefits, and the nature and extent of permanent disability, and being advised of the facts and law, reverses the February 20, 2015 decision of Arbitrator Lindsay, insofar as the Arbitrator concluded that Petitioner failed to prove an accident that arose out of her employment by Respondent. After considering the entire record, the Commission finds Petitioner proved a compensable injury, that is, injury from an accident arising out of and in the course of her employment. The Commission further finds Petitioner incurred permanent partial disability to the extent of 2% loss of use of her left leg. The Commission's reasons are set forth below. The Decision of the Arbitrator is attached hereto and made a part hereof.

Petitioner, Lisa Richmond, 47 years old, was employed as a Certified Nurse Assistant (CNA) by Respondent. On December 22, 2013, she sustained an injury to her left knee when, while waiting for her tray of food at the kitchen on Respondent's premises, she was approached from behind by a co-worker, Celia Hart. Ms. Hart playfully grabbed Petitioner's shoulders, said "gotcha," and kneed Petitioner in the back of her left knee. Petitioner testified that she "[went] over sideways" and felt pain rush up her left leg. Later that day Petitioner presented at Express Medical Care. She was discharged with a knee sprain and told to rest and ice her knee, and to keep it elevated and wrapped with a compression bandage. She returned to Express Medical Care on December 30, 2013 with complaints of ongoing pain and was diagnosed with knee derangement. At that point, she was authorized off work for two weeks. An MRI revealed a complete anterior cruciate ligament tear; extensive complex tear of the medial meniscus, a small tear at the body of the lateral meniscus with associated parameniscal cyst; tricompartmental osteoarthritis with a focal high-grade chondromalacia and medial and patellofemoral

compartments; marrow edema along the posterior aspect of the medial tibial plateau; and a large Baker's cyst.

Orthopedics specialist Dr. Felix Ungacta evaluated Petitioner on February 3, 2014. He diagnosed an anterior cruciate ligament tear and recommended a total knee replacement, or, in the alternative, cortisone injections. He also recommended anti-inflammatory medications and physical therapy, which Petitioner attended. She followed up with the doctor on March 24, 2014 with complaints of left knee pain of "8/10" in intensity. On July 16, 2014, Dr. Ungacta stated that Petitioner might be a candidate for arthroscopic chondroplasty and debridement for pain relief. As of November 5, 2014, Dr. Ungacta's diagnoses remained unchanged – i.e., Petitioner had an anterior cruciate ligament tear as a result of a work-related injury along with concomitant medial compartment arthritis. He recommended either conservative management or a left knee arthroscopy, with no arthroplasty given her age.

Petitioner underwent an evaluation at the request of Respondent by Dr. Michael Nogalski on August 27, 2014. Dr. Nogalski's impression included a strain of the left knee by history with osteoarthritis and an old anterior cruciate ligament injury. He concluded that Petitioner may have sustained a strain to her knee on December 22, 2013, but that other diagnoses pre-existed that condition. Dr. Nogalski felt she had solid mechanical function and findings, and did not believe she required any further evaluation or treatment for her left knee. He noted she had subjective complaints with osteoarthritic issues within the knee, but found no mechanical correlation and could not identify any specific objective or current physical findings to suggest that her pre-existing conditions were accelerated or permanently aggravated by her injury of December 22, 2013. He felt that Petitioner was at maximum medical improvement.

The Arbitrator denied Petitioner's claim in its entirety and awarded no benefits. Specifically, the Arbitrator concluded that Petitioner did not show that the accident "arose out of" her employment, insofar as Petitioner "was not performing tasks to her employer's benefit at the time of her injury." (Arbitrator's Decision at p. 8). The Arbitrator further noted that Petitioner "offered no testimony that the reason for Ms. Hart coming up behind her to say 'hello' had anything to do with her employment, specifically she did not come up to her to discuss a work issue or to bring her something for work." (Arbitrator's Decision at p. 8).

On appeal, Petitioner argued that the Arbitrator's decision is against the evidence and case law. Petitioner pointed to the undisputed facts that she was on the clock, on Respondent's premises, waiting to retrieve her lunch pursuant to Respondent's procedures, when she was excitedly greeted by a co-employee, who was also on the clock, and sustained an injury to her left knee. Petitioner cited County of Cook v. Industrial Commission, 165 Ill. App. 3d 1005 (1988) and Chicago Transit Authority v. Industrial Commission, 141 Ill. App. 3d 868 (1986), two cases involving lunchtime injuries, in support of her position. In these cases, the Appellate Court found that an accident that occurred during a lunch period were compensable where the employee was still on the employer's premises, as the act of procuring lunch was incidental to the employment, even where the injury was not actually caused by a hazard of employment. County of Cook, 165 Ill. App. 3d at 1008; Chicago Transit Authority, 141 Ill. App. 3d at 868

15IWCC0672

In the case at hand, the Arbitrator did find that Petitioner's injury occurred "in the course of" her employment insofar as it happened during her regular work hours. The Arbitrator also found that Petitioner was not participating in the horseplay that led to her injury. (Arbitrator's Decision at pp. 7-8). The Arbitrator correctly noted an injury at work due to horseplay may be found compensable where the injured worker is not an active participant in the horseplay. *See* Pekin Cooperate Co. v. Industrial Board, 277 Ill. 53 (1917) (injury while standing in line for pay compensable where claimant was not participating in the horseplay); Murray v. Industrial Commission, 163 Ill.App.3d 841 (1987). However, the Arbitrator then asserted a requirement that the injury must occur while the claimant is "performing tasks to the employer's benefit." (Arbitrator's Decision at p. 8). Because retrieving one's lunch is not performing a task to the employer's benefit, according to the Arbitrator's reasoning, Petitioner's accident did not arise out of the course of her employment.

However, case law does not appear to establish such a requirement. Indeed, the facts of the instant matter bear a striking similarity to those of Murray v. Industrial Commission, 163 Ill. App. 3d 841 (1987). In Murray, the claimant sought benefits after injuring his knee at work. A co-worker had walked up behind him and tapped him on the back of the leg, which caused the claimant's knees to buckle. He fell to the floor and injured his knee. There was testimony that the tap was a friendly gesture or joke. The arbitrator found the accident arose out of and in the course of his employment. The Commission reversed, finding the claimant did not show that the "assault" was related to the performance of his job duties, nor that his "employment was such as to particularly subject him to the hazard of attack by fellow employees." Murray, 163 Ill.App.3d at 843. The circuit court reversed the Commission on the basis that "horseplay" is compensable in Illinois and that there was no evidence that the co-worker "assaulted" the claimant. The Appellate Court affirmed, reiterating that "Illinois permits the nonparticipating victim of horseplay to recover worker's compensation benefits." Id.

In accordance with that reasoning, the Commission reverses the Arbitrator's Decision and finds that Petitioner proved an accident that arose out of and in the course of her employment.

As to the issue of causal connection between the accident and Petitioner's current ill-being, the Commission observes that Petitioner's underlying condition in all likelihood was primarily chronic and pre-existing. Moreover, the Arbitrator correctly notes the incident was not as severe as the claimant represented it to be at trial, observing "Petitioner's description of the accident has varied and been embellished over time." (Arbitrator's Decision p.7) The Commission also finds noteworthy Dr. Nogalski's finding of no mechanical correlation to her subjective complaints. The Commission is persuaded by the opinions of Dr. Nogalski, who believed that while Petitioner sustained a strain to her knee on December 22, 2013, the other diagnoses pre-existed this condition and were not aggravated or accelerated by it. As such, the Commission finds the requested medical care is not causally related to the workplace accident.

Regarding permanent disability, Petitioner testified, during the Section 19(b) hearing of January 29, 2015, that she returned to full duty on January 14, 2014 and continued working for Respondent until she was terminated for unrelated reasons on or about July 14, 2014. At the time of the hearing, she was working as a CNA at another facility. In determining an appropriate award of permanent partial disability, the Commission considers the factors set forth in Section

15IWCC0672

8.1b of the Act, noting that there is no AMA impairment rating in evidence. The Commission finds that Petitioner sustained 2% loss of use of her left leg, pursuant to Section 8(e) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that the February 20, 2015 Decision of the Arbitrator is reversed, as described above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner temporary total disability benefits of $286.00/week (statutory minimum rate), commencing December 30, 2013 through January 13, 2014, a period of 2 & 1/7 weeks, that being the period of temporary total incapacity from work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner permanent partial disability benefits of $286.00/week (statutory minimum rate) for a period of 4.3 weeks, for the reason that the injuries sustained caused the 2% loss of use of the left leg, as provided in Section 8(e) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the reasonable and necessary medical expenses related to her left knee strain through January 13, 2014, pursuant §8(a) and 8.2 of the Act. Respondent shall be given credit for medical benefits paid and Respondent shall hold Petitioner harmless from any claim by any providers of the services for which Respondent is receiving this credit as provided in Section 8(j) of the Act.

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

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 $2,000.00. 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 the Circuit Court.

DATED: AUG 26 2015

o-08/04/15
jdl/ac
68

Joshua D. Luskin

Ruth W. White

Charles J. DeVriendt

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kenneth Wright,

Petitioner,

vs.

NO: 09 WC 39868

15IWCC0673

FCN Publishing Co. and
State of Illinois, as ex-officio custodian of the Injured Workers' Benefit Fund,

Respondent,

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 5, 2014 is hereby affirmed and adopted.

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

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

15IWCC0673

IT IS FURTHER ORDERED BY THE COMMISSION that the Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $58,000.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 27 2015

David L. Gore

Mario Basurto

Stephen Mathis

DG/mam
o:7/30/15
45

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WRIGHT, KENNETH
Employee/Petitioner

Case# **09WC039868**

15IWCC0673

FCN PUBLISHING CO AND STATE TREASURER OF ILLINOIS AS EX-OFFICIO CUSTODIAN OF THE INJURED WORKERS' BENEFIT FUND
Employer/Respondent

On 9/5/2014, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.05% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4998 LAW OFFICE OF HUGO ORTIZ
4440 S ASHLAND AVE
CHICAGO, IL 60609

3055 POWER & DIXON PC
BERVE POWER
1525 E 53RD ST SUITE 447
CHICAGO, IL 60615

4980 ASSISTANT ATTORNEY GENERAL
COLIN KICKLIGHTER
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

15IWCC0673

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

Kenneth Wright
Employee/Petitioner

Case # **09** WC **39868**

v.

FCN Publishing Co. and
State Treasurer of Illinois, as ex-officio custodian of the Injured Workers' Benefit Fund
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Milton Black**, Arbitrator of the Commission, in the city of **Chicago**, on **May 21, 2014**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **January 7, 2009**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**16,380.00**; the average weekly wage was $**315.00**.

On the date of accident, Petitioner was **50** years of age, ***single*** 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 $**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 $**268.67**/week for **34** weeks, commencing **September 4, 2009** through **April 29, 2010** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from **September 4, 2009** through **May 21, 2014**, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay reasonable and necessary medical services of $**34,029.54**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**268.67**/week for **53.75** weeks, because the injuries sustained caused the **25** % loss of the **left leg**, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**268.67**/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.

The Illinois State Treasurer as *ex-officio* custodian of the Injured Workers' Benefit Fund was named as a co-Respondent in this matter. The Treasurer was represented by the Illinois Attorney General. This award is hereby entered against the Fund to the extent permitted and allowed under §4(d) of the Act, in the event of the failure of Respondent-Employer to pay the benefits due and owing the Petitioner. Respondent-Employer shall reimburse the Injured Workers' Benefit Fund for any compensation obligations of Respondent-Employer that are paid to the Petitioner from the Injured Workers' Benefit Fund.

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

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

Signature of Arbitrator

September 5, 2014
Date

SEP 5- 2014

STATEMENT OF FACTS

Petitioner, Kenneth Wright, who has also gone by the name Kenneth Muhammad, was born on May 11, 1958. (Tr. 9-10). Petitioner has eight children, two of which were minors at the time of the accident. (Tr. 50). At the time of hearing, Petitioner was unemployed and further testified that he last worked in either February or March of 2009 for the Respondent, Final Call Newspaper. (Tr. 10). Petitioner understood that the Final Call Newspaper was his employer at the time. *Id.* The Final Call is located at 920 West 79th Street in Chicago. (Tr. 10-11). FCN Publishing publishes the Final Call Newspaper, as well as audio tapes, videos and CD's. (Tr. 51). In its office and as part of the publishing process, the Final Call uses copy machines, computers and other electronic devices which Petitioner used as part of his work duties. (Tr. 71-72).

As of January 7, 2009, Petitioner had been working for the Final Call for almost ten years after Minister Farrakhan hired him at a meeting. (Tr. 11). The meeting was held overseas and Minister Farrakhan introduced Petitioner as now working for the Final Call. (Tr. 11-12). At the time his employment began, Petitioner's supervisor was James Muhammad. (Tr. 13). Petitioner's job title was staff photographer. (Tr. 14). The Final Call Newspaper listed Petitioner as staff photographer with his former name, Kenneth Muhammad upon starting his employment. (Tr. 15, 157, PX. 7). Specifically, the August 11, 2009 issue of the Final Call Newspaper contained Petitioner's name as staff photographer in the list of staff and different positions for the newspaper. *Id.* As part of his employment, Petitioner had between one and two weeks of vacation yearly as well as sick days. (Tr. 16). Petitioner did not hold any other job titles during his employment.

Petitioner's job duties included covering news events in the City of Chicago as well as around the country and sometimes around the world. *Id.* Petitioner also covered events at Minister Farrakhan's home and other officials' homes. (Tr. 16-17). Petitioner would also look for pictures on the news wire to be used in the newspaper in addition to taking pictures and getting caption information. (Tr. 17). Petitioner testified that a typical event he would cover is Savior Day, an annual event in which he would take photographs for the newspaper. (Tr. 17-18). The photographs Petitioner took at such events had to be related to the contents of the Final Call Newspaper. (Tr. 19).

As part of his work duties, Petitioner was required to travel to take photographs for the Final Call Newspaper. *Id.* Petitioner would have to travel in order to do his job because he would have to go to different locations to take pictures. *Id.* Petitioner was required to travel throughout the City of Chicago and sometimes across the country. *Id.* In order to get to the various sites, Petitioner used his own transportation at one point, but the majority of the time he used public transportation, namely the CTA. (Tr. 19-20). At one point, the Final Call Newspaper paid for Petitioner's transportation. (Tr. 20). The Final Call also reimbursed Petitioner for his transportation costs for some time, but then ceased to do so. *Id.*

Petitioner worked for the Final Call six days per week, but would have to work on off days if something would happen for him to cover. (Tr. 21). Petitioner was on call if a newsworthy event occurred, and the Final Call's editor or other staff would contact Petitioner if the newspaper needed photographs for such an event. *Id.* Petitioner would typically start his work day at either 9:00 a.m. or 10:00 a.m. and would end at either 6:00 p.m. or 7:00 p.m. (Tr. 22). The editor for the Final Call Newspaper determined Petitioner's schedule. *Id.*

Petitioner was required to report to the Final Call Newspaper's office often or whenever it was logistically practical. (Tr. 23). On those days Petitioner did not go to the office, he would be required to notify his employer, Fontaine Muhammad, by phone call or email. *Id.* Specifically, Petitioner was required to call or email either Fontaine Muhammad or the editor of the paper to notify them that he would be late to the office or that he had to get to an assignment. (Tr. 24-25). The emails also contained specific information about

Petitioner's absence from the office to cover a story. (Tr. 25). Petitioner would go to the office four to five days a week, and he was required to sign in and out. (Tr. 26).

The editors of the Final Call would also call Petitioner directly on a daily basis to have him cover a particular event. (Tr. 25). When Petitioner was not out covering an assignment, he would be in the Final Call's office working on his photographs and gathering other photographs from news lines such as the Associated Press. (Tr. 27). While Petitioner had the freedom to choose the stories he would cover, he would have to get approval from the editor or Fontaine Muhammad. (Tr. 28).

During his employment with FCN Publishing, Petitioner also did freelance work with other publications such as the Chicago Defender. *Id.* However, Petitioner did not work out of the Chicago Defender's office, or any other publication's office. (Tr. 150). He did not report to those publications nor was he required to obtain approval prior to pursuing a story. (Tr. 151). Petitioner would merely offer photographs to those publications if he had not used them for the Final Call. (Tr. 151-152). Petitioner testified that the Final Call editors knew that Petitioner freelanced with other publications. (Tr. 28-29). However, the photographs that Petitioner typically took were used only by the Final Call. (Tr. 29). Petitioner's understanding was that during his employment, Respondent could have fired him at any point if he did not report to work. *Id.*

The Final Call owned the photographs that Petitioner took for it during his employment. (Tr. 29-30). It was always his understanding that those photographs were not for Petitioner to keep. (Tr. 30). Petitioner was required to give those pictures to the editor of the Final Call, as well as turn in negatives and memory cards. *Id.* When Petitioner's employment ended, the Final Call sent someone to his house to retrieve whatever photographs he had owned by them, which were recorded either on CD or memory card. (Tr. 31). Fontaine Muhammad told Petitioner that he did not own the pictures he took. (Tr. 144). The Final Call also owned the cameras, Nikon models D100 and DF4, that Petitioner used to take photographs for it. (Tr.31- 32). When Petitioner's employment ended, he had to return the camera to the Final Call. (Tr. 32-33). At the time of injury, Petitioner exclusively used cameras owned by the Final Call. (Tr. 143).

Petitioner testified that he earned approximately $650 every two weeks. (Tr. 33). Upon being shown copies of past check stubs, Petitioner's memory was refreshed that his pay was $630.00 every two weeks. (Tr. 34, PX. 8). Petitioner testified that his pay check was $700.00 every two weeks until child support and loan deductions resulted with $630.00 biweekly checks. (Tr. 34). While his pay checks designated his wages as charity, Petitioner understood the pay to be in return for his work. (Tr. 154). The Final Call deducted child support payments and repayment of a loan to Petitioner from Petitioner's biweekly paycheck. (Tr. 35-36). Petitioner did not file any income tax returns for 2009 or the years he worked with the Final Call, nor were income taxes deducted from his pay checks. (Tr. 142).

Petitioner testified that he worked on January 7, 2009. (Tr. 36). Petitioner arrived at the Final Call's office at about 9 or 10 a.m. (Tr. 37). He signed in and proceeded to work on finding a news event to cover. *Id.* Petitioner found a story about the fire death of three infants of single mothers. (Tr. 37-38). Prior to pursuing the story, Petitioner had to tell his supervisor, Tomika Muhammad and Richard Muhammad, the editor. *Id.* He was required obtain approval prior to pursuing the story. *Id.* Petitioner had to then leave the office to take photographs at the scene of the story, but he was required to sign out of the office. *Id.* Petitioner was required to return to the office after completing his story, and was not free to go anywhere else unless he had another assignment. (Tr. 39-40).

On January 7, 2009, the story Petitioner chose to pursue was set on south 83rd street in Chicago's east side near South Shore Drive. (Tr. 40). Because Petitioner did not own his own vehicle at the time and nobody at the Final Call offered to drive him, he was required to take public transportation to the scene. (Tr. 40-41). Petitioner left the Final Call's office at 11:00 a.m. to go to the scene of the story. (Tr. 41). Petitioner got on the CTA bus at the stop located across the street from the Final Call's office going eastbound on 79th street. (Tr. 41-42). Petitioner had to take a second bus at 79th and South Shore Drive traveling southbound toward his destination. (Tr. 42-43). Taking the second bus was necessary to get to the scene of Petitioner's assignment. (Tr. 43).

Upon boarding the second bus, Petitioner took three or four steps when he slipped and fell. *Id.* The bus began to move and the force of the bus moving made Petitioner's right leg slip in front of him, leaving his left leg behind him. (Tr. 43-44). Petitioner's left leg was bent at the knee under him. (Tr. 44). The fall also caused Petitioner to hit his back and left arm as he impacted the bus floor. (Tr. 45). Petitioner testified that he felt unbearable pain throughout his left leg, left shoulder and left wrist. *Id.* Petitioner was unable to get up following his fall. *Id.*

Following Petitioner's fall, an ambulance was called to the scene to transport Petitioner to the hospital. (Tr. 48). The Chicago Fire Department ambulance arrived to the scene and found Petitioner lying on his back. (PX.1, p. 1). The ambulance transported Petitioner to South Shore Hospital where he presented with pain to his left leg and left shoulder. (Tr. 52-53, PX. 2, p. 4). Petitioner told the emergency physician how he was injured on the bus. (Tr. 53, PX. 2, p. 4). Petitioner recalled that his leg was swollen two to three times the normal size at the time he was at the emergency room. (Tr. 54). Petitioner underwent x-rays to his left shoulder and left knee. (PX. 2, p. 10-11). The left knee x-ray revealed soft tissue swelling with suspected suprapatellar joint effusion, among other things. (PX. 2, p. 10). Petitioner was discharged from care with diagnoses of left shoulder and left knee contusions, and was given pain medication. (PX. 2, p. 7-8). He was also given crutches and a cane to use. (Tr. 54). Petitioner was to follow up with his physician, but the MRI that was recommended "went nowhere" because Petitioner could not afford it. (Tr. 55).

On February 3, 2009, Petitioner sought treatment at Stroger Hospital due to continuing pain to his left leg, right arm, and left ankle. (Tr. 57). Petitioner's left leg was still swollen at the time. *Id.* Petitioner underwent additional x-rays at Stroger, which revealed similar results as the x-rays performed at South Shore Hospital. (Tr. 57, PX. 3, p. 17-20). At the time Petitioner went to Stroger, he was still unable to walk. (Tr. 58). Petitioner's left leg continued untreated. (Tr. 59).

Petitioner next sought treatment at OAK Orthopedics with Dr. Kermit Muhammad on March 20, 2009. (Tr. 59, PX. 4, p. 3). Petitioner was referred to OAK by Dr. Robert Muhammad, whom Petitioner saw at his

office on the south side of Chicago. (Tr. 59-60). Petitioner had run into Dr. Robert Muhammad at Savior's Day shortly following the accident. (Tr. 66). Petitioner explained his symptoms to Dr. Kermit Muhammad and how the accident occurred. (Tr. 60, PX. 4, p. 3). Dr. Kermit Muhammad recommended an MRI of Petitioner's left leg, which he underwent on March 20, 2009. (Tr. 60, PX. 4, p. 1-2). The MRI revealed a full thickness tear of the distal quadriceps tendon with a 1.6-cm fluid-filled gap, a mild sprain of the medical collateral ligament, and joint effusion. (PX. 4, p. 2). Dr. Kermit Muhammad immediately recommended surgery to Petitioner's left knee. (Tr. 61, PX. 4, p. 5). Dr. Kermit Muhammad noted the difficulty of repairing Petitioner's torn tendon given the length of time it had remained injured, as well as the lengthy period of recovery that would be needed. (PX. 4, p. 11-14). Dr. Kermit Muhammad determined that Petitioner was to remain off-work. (PX. 4, p. 15).

On March 26, 2009, Petitioner underwent left knee surgery at Riverside Medical Center performed by Dr. Kermit Muhammad. (Tr. 61, PX. 5, p. 171-172). The surgery helped Petitioner's leg recover. (Tr. 61). Over a year after the surgery, Petitioner completed a course of physical therapy at Accelerated Rehabilitation Center. (Tr. 62, PX 6, p. 17-18). Petitioner presented to Accelerated Rehabilitation Center feeling very tight as he had to relearn how to walk all over again. (Tr. 62). Petitioner's rehabilitation consisted of stretching, walking, taking steps, strength training and massages with hot and cold pads. (Tr. 63). The physical therapy helped Petitioner and he was able to walk again. *Id.* Petitioner was deemed to be at maximum medical improvement at the time he completed his rehabilitation. *Id.* Petitioner was eventually able to work again. (Tr. 64).

Petitioner was taken off of work from every doctor he saw. *Id.* Petitioner would get paperwork sent to his employer by fax or email, and he would be copied on the correspondence sent to his employer. (Tr. 64-65). Despite being taken off of work, Petitioner worked a few days in February 2009 during the Savior's Day event. (Tr. 65-66). He did not work thereafter. (Tr. 66). Dr. Kermit Muhammad had given Petitioner light duty restrictions during his recovery. (Tr. 66, PX. 4, p. 17). However, those restrictions were not accommodated by the Final Call. (Tr. 67). Petitioner's last paycheck was for September 2, 2009. *Id.* He did not receiving any pay or benefits from September 4, 2009 to April 29, 2010. *Id.*

Prior to this work injury, Petitioner had some problems with both his legs due to a 2001 injury. *Id.* However, Petitioner did not have as severe problems with his left quadriceps tendon as he did following the accident. (Tr. 68, 155). Prior to the work injury, Petitioner was able to walk normally and walk up and down stairs normally. *Id.* Prior to the work injury, Petitioner did not have any problems with his left shoulder. *Id.* To this day, Petitioner continues to experience weakness and buckling to his left knee when he walks. (Tr. 68-69). Petitioner continues to require the assistance of a cane to walk. (Tr. 69). Petitioner continues to experience limited mobility to his left shoulder. *Id.* As to his medical bills, it is Petitioner understands that they have not been paid and remain outstanding. (Tr. 69-70).

Petitioner reported the work accident to Richard Muhammad, the editor of the Final Call Newspaper at the time of injury. (Tr. 48). The report was made by Petitioner's girlfriend on his behalf. (Tr. 48-49). The day following the accident, Petitioner reported the accident himself to the editor. (Tr. 49). Petitioner reported to the editor that he could not walk as a result of the injury he had suffered. *Id.* Petitioner testified that the editor was aware that he had been on his way to cover a story at the time of injury. (Tr. 49-50).

On cross-examination, Petitioner testified that he was diligent in getting medical treatment for his injured knee. (Tr. 72). Petitioner affirmed that the medical reports associated with his treatment relating to his injury are accurate. (Tr. 76-77). He further testified that while he did not have an employment contract with the Final Call, his name was contained in the newspaper indicating his employment. (Tr. 80). Petitioner testified that he was credited with his photographs differently after becoming an employee of the Final Call compared to when he was a freelance photographer for the newspaper. (Tr. 82-83). Instead of being credited as Kenneth Wright, he was credited as Kenneth Muhammad. *Id.* With respect to the process of pursuing a story, Petitioner testified that he could not just get up and walk out of the building because he had to let the editor know what he would be doing. (Tr. 103).

On re-direct examination, Petitioner testified that after the work accident, he was in contact with the attorneys for the Final Call. (Tr. 157). Petitioner testified that he received his last paycheck from the Final Call

and a letter indicating he would no longer receive any more pay. *Id.* The letter was dated September 3, 2009 and addressed to Petitioner at his former address. (Tr. 159, PX. 10). Petitioner testified that there was letterhead on it saying "the law office of Power and Dixon." *Id.* The letter indicated that the law office of Power and Dixon represents the Nation of Islam and all of its affiliates including the Final Call Newspaper. (Tr. 159-160, PX. 10). Most notably, the letter states that Petitioner was once employed by the Final Call as a photographer, but that he had not been actively working for the Final Call for several months. (Tr. 160, PX. 10). The letter further states that all payments the Final Call made to Petitioner after the accident were gratuitous. (Tr. 161, PX. 10). Upon receiving this letter, Petitioner understood that he had been fired from the Final Call. (Tr. 162). The letter further memorialized Petitioner's reporting of his work accident to the Final Call. (Tr. 163, PX. 10). The letter was signed by Brandon McRoyal, who Petitioner understood to be an attorney from Power and Dixon. (Tr. 160-161, PX. 10).

CONCLUSIONS OF LAW

With Respect to Issue A, whether Respondent was operating under and subject to the Illinois Workers' Compensation Act, the Arbitrator concludes:

The Arbitrator concludes that based on Petitioner's unrebutted, credible testimony, Respondent, the Final Call Newspaper, was operating under and subject to the Illinois Workers' Compensation Act on January 7, 2009. Section 3 of the Illinois Workers' Compensation Act provides, in relevant part:

> §3 Automatic Coverage
> Section 3. The provisions of this Act hereinafter following shall apply automatically and without election to the State, county, city, town, township, incorporated village or school district, body politic or municipal corporation, and to all employers and all their employees, engaged in any department of the following enterprises or businesses which are declared to be extra hazardous, namely:
> ...
> 15. Any business or enterprise in which electric, gasoline or other power driven equipment is used in the operation thereof.
>
> 820 ILCS 305 (West 2010).

Petitioner unrebutted testimony was that the Final Call uses computers, copy machines and other electronic equipment to operate its business. Based on the preponderance of the evidence, the Arbitrator concludes that the Final Call was operating under and subject to the Illinois Workers' Compensation Act.

With Respect to Issue B, whether there was an employee-employer relationship between Petitioner and Respondent, the Arbitrator concludes:

The Arbitrator concludes that, based on Petitioner's unrebutted, credible testimony and the evidence submitted at trial, an employee-employer relationship existed between Petitioner and the Final Call. The Arbitrator notes the letter Petitioner received from the Final Call's attorneys which clearly indicates Petitioner was the Final Call's employee at the time of the accident. (PX. 10). The letter provides, in relevant part:

> Please be advised that the Nation of Islam and all affiliates and entities are represented by the Law Offices of Power & Dixon, P.C. It is our understanding that while you were once employed by *The Final Call* as a photographer, you have not been actively working for *The Final Call* for several months. (emphasis in the original) (PX. 10).

The letter further shows that Petitioner was paid a wage in return for his work as staff photographer, and that he was terminated from his employment at that time. *Id.* Petitioner's unrebutted testimony further revealed that he was hired by Minister Farrakhan during an event in which Petitioner was introduced as working for the Final Call. Additionally, Petitioner's name was printed in the Final Call Newspaper as staff photographer among other staff members' names, including the editors. (PX. 7).

Petitioner's credible testimony revealed that the Final Call required him to notify the editor or supervisor of where Petitioner would be going to cover a story. Petitioner was required to obtain approval for stories he decided to pursue. Petitioner also had to work out of the Final Call office whenever he was not out covering a story. When he did have to go somewhere to cover a story, he would have to call or email the editor or a supervisor before doing so. Petitioner was not free to just walk out of the Final Call's office when he worked office hours, and he was required to sign in and sign out of work.

The nature of Petitioner's work is directly related to the business of the Final Call. As staff photographer, Petitioner was instrumental to the Final Call's publishing of its newspaper.

The Final Call paid Petitioner's wages in biweekly paychecks.

As evidenced by the letter from the Final Call's attorneys and Petitioner's unrebutted testimony, the Final Call had the right to discharge Petitioner and did so with the aforementioned letter.

Petitioner's work required skill not only in photography, but also in identifying newsworthy events and researching existing photographs in the Final Call's library that would be useful for any particular story.

Petitioner's unrebutted testimony revealed that his camera, his necessary tool, he had been using at the time of his accident belonged to the Final Call. He had been using a camera issued by the Final Call for several years at the time of injury.

Petitioner's testimony showed that the Final Call also owned the photographs he took for the paper, and that officials from the Final Call went to Petitioner's home following his termination to recover said photographs and the media on which they were stored.

Therefore, the Arbitrator concludes that the Final Call employed Petitioner at the time of the accident.

With Respect to Issue C, whether an accident occurred arising out of and in the course of Petitioner's employment by Respondent, the Arbitrator concludes:

The Arbitrator concludes that the Petitioner credibly testified that he was performing work duties that arose out of and in the course of his employment with the Final Call when he suffered injuries to his left leg and left shoulder.

The Arbitrator concludes that Petitioner was a traveling employee required to travel in order to perform his work duties. The Arbitrator further concludes that Petitioner's injury sustained as a traveling employee arose out of his employment because he engaged in conduct that was reasonable and foreseeable. Petitioner credibly testified that on January 7, 2009, he left the Final Call's office around 11:00 a.m. to take the bus to the scene of a story he was to cover that day. Petitioner testified that it was necessary for him to travel to different places in

order to take photographs for the stories he was assigned to cover. Petitioner had to take public transportation because he did not have his own transportation and the Final Call also did not provide it.

Petitioner further testified that on January 7, 2009, he was required to take two buses to the scene of a fire which claimed the lives of three children. He had deemed this story newsworthy, obtained approval from the editor to pursue it and promptly took the first CTA bus. On the second CTA bus, he sustained his injury when he fell as the bus pulled away. It was reasonably foreseeable to the Final Call that their staff photographer who was required to travel frequently to cover stories would take public transportation and could be injured in an accident. This is particularly true considering the nature of Petitioner's work duties which were essential for the Final Call's publishing of its newspaper. Accordingly, based on Petitioner's unrebutted, credible testimony, the Arbitrator concludes that Petitioner suffered injuries arising out of and in the course of his employment with the Final Call.

With Respect to Issue D, what was the date of the accident, the Arbitrator concludes:

The Arbitrator concludes that the date of accident was January 7, 2009. Petitioner credibly testified that on said date, he sustained injuries to his left leg and left shoulder when he slipped and fell on a CTA bus as he traveled to cover a story for the Final Call. Furthermore, Petitioner's medical records consistently show the date of injury as January 7, 2009. The Chicago Fire Department ambulance report clearly indicates January 7, 2009 as the date Petitioner was picked up by the ambulance and transported to South Shore Hospital. (PX. 1).

With Respect to Issue E, whether timely notice of the accident was given to Respondent, the Arbitrator concludes:

The Arbitrator concludes that Petitioner gave timely notice of the accident to the Final Call. Petitioner's credible and unrebutted testimony revealed that while he was in the hospital, he had the nurse tell his girlfriend to notify the editor of the Final Call that he had been injured. Petitioner further testified that the following day, he told the editor, Richard Muhammad that he had been injured on his way to cover a story. The letter Petitioner received from the Final Call's attorney reflected the Final Call's knowledge that Petitioner could no longer

work in March 2009 due to his injury on January 7, 2009. Petitioner's medical records are consistent that he suffered injuries from a work-related accident. (PX. 4, p. 3). The Final Call did not offer any evidence to indicate that the accident occurred elsewhere or under different circumstances. Based on Petitioner's unrebutted testimony, the Arbitrator concludes that timely notice of this accident was given to Respondent.

With Respect to Issue F, whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator concludes:

The Arbitrator concludes that Petitioner's current condition of ill-being is causally related to the injury. The Arbitrator notes that the chain of events, medical evidence, Petitioner's testimony as to the mechanism of injury, his symptoms and medical treatment, Petitioner has proven based on a preponderance of the evidence that his left leg and left shoulder injuries are causally related to this work accident. Petitioner testified that, prior to this work accident, he did not have any significant symptoms or pre-existing conditions to either his left leg or his left shoulder. Petitioner testified that while he had injured his left leg several years before this work accident, the severity of that injury was minor compared to the traumatic injury he suffered on January 7, 2009. Specifically, Petitioner testified that he did not have a torn left quadriceps tendon or injured left shoulder. Petitioner further testified that prior to this work injury, he was able to walk normally and was able to walk up and down stairs much better than he could following the accident.

Petitioner's medical records, specifically Dr. Kermit Muhammad's reports, repeatedly cite Petitioner's condition of ill-being to the injuries he sustained in his work accident on January 7, 2009. The objective medical evidence, namely the MRI of the left leg and other diagnostic exams performed on Petitioner's left leg and left shoulder established that Petitioner suffered from a torn quadriceps tendon and a severe shoulder strain. The Arbitrator notes that there is no medical opinion to rebut the opinions of Petitioner's treating physicians.

Accordingly, the Arbitrator concludes that Petitioner has proven by a preponderance of the evidence that his condition of ill-being is causally related to his work injuries sustained on January 7, 2009.

With Respect to Issue G, what were Petitioner's earnings, the Arbitrator concludes:

The Arbitrator concludes that Petitioner's earnings in the year preceding his injury were $16,380.00, resulting in an average weekly wage of $315.00. Petitioner's credible, unrebutted testimony revealed that he was paid biweekly checks in the amount of $630. Petitioner further presented check stubs he received from the Final Call confirming his weekly earnings of $315.00. (PX. 8).

Accordingly, the Arbitrator concludes that Petitioner's earnings were $16,380.00, or $315.00 per week.

With Respect to Issue H, what was Petitioner's age at the time of the accident, the Arbitrator concludes:

The Arbitrator concludes that Petitioner was 50 years old at the time of the accident. Petitioner's credible, unrebutted testimony coupled with his medical records clearly shows that he was born on May 11, 1958. The Arbitrator notes that the Final Call did not offer any evidence to the contrary.

Accordingly, the Arbitrator concludes that Petitioner was 50 years old at the time of injury.

With Respect to Issue I, what was Petitioner's marital status at the time of the accident, the Arbitrator concludes:

The Arbitrator concludes that Petitioner was single at the time of the accident. Petitioner's medical records consistently show that he was single on January 7, 2009. Petitioner's records from South Shore Hospital where he was transported by ambulance for emergency treatment show that he was single. (PX. 2, p. 1).

Accordingly, the Arbitrator concludes that Petitioner was single at the time of the accident.

With Respect to Issue J, whether the medical services that were provided to Petitioner were reasonable and necessary? Whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator concludes:

The Arbitrator concludes that the medical services that were provided to Petitioner were reasonable and necessary. Petitioner's treating physicians were able to identify the sources of Petitioner's symptoms and assist him with pain management, repair his full thickness tear of his quadriceps tendon, and then provide physical therapy. Petitioner underwent x-rays and an MRI to his left leg in order for his physicians to diagnose his torn tendon. The medical records from Dr. Kermit Muhammad and OAK clearly show that surgery was necessary

for Petitioner to be healed of his symptoms. Petitioner testified that the treatment he received helped him recover. The Arbitrator notes that there are no opinions to rebut Dr. Kermit Muhammad's opinions or to contradict the reasonableness of Petitioner's treatment.

The Arbitrator concludes that Petitioner has proved by a preponderance of the evidence that the medical services provided to him were reasonable, necessary and related. Petitioner testified that all his bills remain outstanding. Accordingly, Petitioner is awarded the following outstanding medical benefits pursuant to the medical fee schedule:

PROVIDER	Charges
Chicago Fire Department:	$651.00
South Shore Hospital:	$764.00
South Shore Radiologists:	$75.00
OAK Orthopedics:	$6,755.00
Riverside Medical Center:	$15,260.85
Accelerated Rehab Center:	$7,530.00
Stroger Hospital:	$53.69
Illinois Anesthesia Associates:	$2,940.00
Total Medical Awarded:	$34,029.54

With Respect to Issue K, what temporary benefits are in dispute, the Arbitrator concludes:

The Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he was temporarily totally disabled from September 4, 2009 to April 29, 2010, representing 34 weeks. Petitioner testified that he was taken off of work by his treating physicians or otherwise given light duty which the Final Call did not accommodate. He was incapacitated or otherwise not accommodated from September 4, 2009 to April 29, 2010. On April 29, 2010, he was released from care from Accelerated Rehabilitation and returned to work. Accordingly, the Arbitrator concludes that Petitioner is entitled to $268.67 weekly for 34 weeks of temporary total disability benefits, totaling $9,134.78, as he had two dependents at the time he was injured.

With Respect to Issue L, what is the nature and extent of the injury, the Arbitrator concludes:

The Arbitrator concludes that the nature and extent of Petitioner's injuries to his left leg is 25% loss of use of the left leg. The Arbitrator further finds that's the nature and extent of Petitioner's injuries to his left

shoulder is 2% loss of the person as a whole. The Arbitrator notes that through Petitioner's credible testimony and the medical records, Petitioner suffered a full thickness tear of his quadriceps tendon as well as a left shoulder strain when he fell on the CTA bus en route to cover a story. Petitioner underwent surgery to his left knee followed by physical therapy to both his left leg and left shoulder. The Arbitrator further notes that the mechanism of injury is supported by the medical records presented by Petitioner. The medical records show that Petitioner complained of pain to both his left leg and left shoulder following his slip and fall. Petitioner did not have any significant injuries or pre-existing conditions to his left leg or left shoulder prior to this work accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

FANNY KAPUSTA,
Petitioner,

v.

15IWCC0674

No. 03 WC 6815

LAWSON PRODUCTS,
Respondent.

DECISION ON PETITION UNDER §19(h)

This matter comes before the Commission on Petitioner's Petition under §19(h). A hearing was held on Petitioner's Petition on September 20, 2014 in Chicago before Commission White. Both parties were represented by counsel and a record was taken.

In the underlying cases, the Arbitrator issued a decision on June 17, 2005, in which he found Petitioner suffered a work-related accident on November 5, 2002 and awarded her 5&3/7 weeks temporary total disability benefits and 77.5 weeks of permanent partial disability benefits representing loss of 50% of the right foot. Respondent sought review of that decision and the Commission modified the Decision of the Arbitrator. The Commission reduced the average weekly wage from $755.22 to $746.00, based on a stipulation of the parties, reduced the benefit rates in accordance with the modified average weekly wage, increased temporary total disability benefits to 16 weeks, and specified the award of medical expenses. Petitioner filed her Petition for Review under §19(h) on September 28, 2009.

Findings of Fact and Conclusions of Law

1. Petitioner testified that on November 5, 2002 she tripped over an open file cabinet drawer; her right foot "did not come with" her. She received an award of 50% loss of the right foot. Since the award she was told the screws in her right foot are broken. That has caused her foot to become destabilized. It causes "chronic pain and terrible, terrible cramping" in her foot and lower calf. She wakes up screaming two or three times a week. She uses orthopedic shoes and walked in a CAM walker because Dr. Kudrna told her "it was ruining" her hip.

2. She had a §12 medical examination with Dr. Holmes on October 24, 2013 who told her "absolutely the only way to fix this was to do another surgery." He recommended removing the screws and fusing the foot and the ankle was also destabilized; "that was never repaired originally, so he needs to go in and repair that as well."

3. Petitioner also testified that originally, she was able to control her pain through Tylenol, massage therapy, and physical therapy, but now nothing helps "not Tylenol, not prescriptions." She was using a cane because of her foot. Her general practitioner, Dr. Muzammil, recommended she use it. She cannot walk as much as she used to. She is an artist and she can't attend festivals and art fares, or go to museums because there is too much walking. She informed the attendees of the hearing that it was going to rain later in the day and because of the pain she was "feeling today it is going to be a doozy."

4. Petitioner indicated she could not get the foot surgery because she already had "6, 7, 8, 9" hospitalizations for recurrent bowel obstructions, Crohn's flare up, a pilonidal cyst removal, and breast reduction. Initially, she could handle the condition, but currently she cannot. She hopes that the recommended fusion surgery could help her return to work, though she acknowledged other health issues. No other treatment had been recommended to her.

5. On cross examination, Petitioner testified she believed the recommended surgery was approved by insurance. She agreed that "the reason it has taken this long is because of these other issues." Chubb has approved medication for her foot condition.

6. On April 21. 2005, Petitioner returned to Dr. Kodros, who performed open reduction with internal fixation surgery on her foot two years earlier. He noted she continued to have some pain in the midfoot, mostly associated with weightbearing. She did pretty well in gym shoes but had difficulty finding dress shoes she could wear. Petitioner had been using a postop shoe which seemed to work, but she had "difficulty with it breaking down."

7. X-rays findings were consistent with posttraumatic arthritis. Dr. Kodros agreed to prescribe a hinged CAM boot for Petitioner to use as needed. They discussed that if her difficulty persisted, arthrodesis of the affected joints would be the only surgical option.

8. Petitioner continued to complain of foot pain to Dr. Kodros over the next four-year period. Dr. Kodros continued to treat her conservatively.

9. On November 6, 2008 Petitioner presented to Dr. Kudrna who noted Petitioner had a 6-year history of dealing with a Lisfranc nonunion and cuboid fracture. She was walking in a boot. She had really sharp hip pain that can radiate all the way into the back. Dr. Kudrna ordered a bone scan to evaluate inflammatory arthritis.

10. On December 4, 2008, Dr. Kudrna noted the bone scan taken November 22, 2008 showed "literally normal hips." He thought she had "pretty much referral of pain from her lumbar spine and from her ambulatory patterns here because of the Lisfranc issue."

11. On May 14, 2009, Petitioner returned to Dr. Kodros and reported chronic pain in various areas. He noted that the only thing that appeared to manage her activity-related symptoms was use of the CAM boot. X-rays still showed the hardware intact and the foot in proper alignment. He noted posttraumatic arthritis and possible metatarsalgia. However, "the relative severity and diverse nature of her pain and symptoms and limited response only to the use of a CAM walker, would seem to be not readily explainable by these entities alone."

12. At that time, Dr. Kodros was reluctant to recommend surgery due to the diffuse nature of Petitioner's symptoms because surgery may not provide her "overall therapeutic response even if successful and uncomplicated." He recommended continued conservative treatment and a new solid brace.

13. An MRI taken August 22, 2009 showed mild edema at the insertions of the gluteus medius and minimus tendons upon the right greater trochanter, mild edema of the greater trochanters bilaterally possible representing trochanteric bursitis, and mild diffuse bilateral atrophy of the gluteus maximus muscles.

14. On October 3, 2009, Petitioner returned to Dr. Kudrna regarding her right hip pain around the trochanter area into the right groin. Dr. Kudrna noted the MRI showed the hip was "clean save some tendinopathy." Dr. Kudrna indicated they could go ahead with an injection, but as she was "walking around with this poor situation with the foot" he thought she would "continue to irritate the abductors." Therefore, she was going to get a 2nd opinion regarding the foot.

15. Petitioner had a § 12 medical examination with Dr. Virkis on March 30, 2011 regarding her hip condition. In his report, Dr. Virkis noted Petitioners' date of initial injury was November 5, 2002 and she last worked in October of 2009. Her injury was a Lisfranc fracture and she was treated by Dr. Kodros. Over the last few years she experienced increasing hip, neck, and back pain. In particular her right hip began hurting two years previously. On average the hip pain was 7/10 and she had trouble sleeping and walking/standing. She had numerous neck, shoulder, and spine injections and that, as well as recurrent Crohn's disease, which was the reason she did not have treatment for her hip. She was planning on getting injections under the supervision of Dr. Kudrna in the near future.

16. Dr. Virkis noted that on examination, Petitioner showed tenderness to palpitation far in excess of what would be expected. She showed global weakness on the right, particularly in the abductors and quadriceps. There was also weakness in the dorsiflexors. Petitioner was "hyperreflexic bilaterally at the ankles and knees,

with bilateral clonus in the legs." The rest of the neurological exam was normal. An MRI taken August 22, 2009 showed mild edema at the insertions of the gluteus medius and tenderness compatible with insertional strains. A bone scan was essentially normal regarding the hip.

17. Dr. Virkis diagnosed irritable right hip from an unknown etiology. He noted that diagnosis was difficult because of symptom magnification. He did not feel her hip complaints were related to her accident of November 2002, or to overuse because of the need to wear a boot. He noted that Petitioner walked with a Trendelenburg gait on the left, placing greater weight on the left. He also did not believe her back complaints were related to her accident noting that she did not have treatment for that or her hip for several years after the accident. She was not at maximum medical improvement because she was due for injections. Thereafter, she should have strengthening physical therapy at which time she would be at maximum medical improvement. Petitioner subjectively reported that she cannot walk or sit for prolonged periods. However, because Petitioner's previous job was a desk job, she should not need any work restrictions.

18. Another MRI was taken on December 23, 2011 showed mild degenerative changes in the right hip with diffuse grade II/III chondral thinning posteriorly in the joint, suspected small CAM type deformity along the anterior femoral head neck junction, suggesting possible femoral ancetabular impingement, and degenerative changes in the labrum without discrete tear. An arthrogram provoked 5/10 pain response at its highest.

19. On February 24, 2012, Dr. Kudrna wrote an open letter indicating Petitioner had worn a CAM boot for 10 years for a condition unrelated to her hip. "Because of the boot, the pain in her hip has increased. This may have aggravated the painful right hip." He recommended consultation at the Mayo Clinic.

20. Dr. Holmes performed an examination of Petitioner pursuant to §12 of the Act on November 7, 2013 regarding her foot condition. He noted that Petitioner had open reduction and internal fixation of the 1st and 2nd TMT joints, uneventful postoperative recovery, and extensive physical therapy. She was returned to work on February 5, 2003 at maximum medical improvement, at which time it was noted that she may need a fusion in the future. On July 22, 2013, a fusion was recommended, apparently by Dr. Levi, even though no records of Dr. Levi are included in the transcript.

21. Dr. Holmes noted that Petitioner saw Dr. Kodros the previous summer who opined she did not need any additional treatment. She was taken out of her CAM walker about two years previously by her hip surgeon because it was thought that was causing problems with her hip. Currently, Petitioner reported a dull throbbing pain and swelling over the midfoot and dorsal aspects of the foot with some radiation into the ankle and great toe. The pain was worse with weightbearing. Petitioner left work in 2009 due to other health issues.

22. Dr. Holmes indicated that x-rays showed screwed fixation from 1st cuneiform to the 2nd metatarsal and from the 1st metatarsal to the 1st cuneiform and persistent patency at the joint between the 1st cuneiform to the 2nd metatarsal. The 2nd joint appeared to be properly fused, but the screw from the 1st metatarsal to the 1st cuneiform was broken. The x-rays also suggested a crack in the cuboid, representing an old injury. Dr. Holmes diagnosed posttraumatic arthritis.

23. Dr. Holmes opined that Petitioner's condition had not satisfactorily responded to conservative treatment. He provided a "qualified" agreement with the recommendation of Dr. Levi for a fusion, because Petitioner's co-morbidities may defeat a successful union. She would probably need a bone graft. He did not believe repair of the cuboid crack was necessary. Dr. Holmes opined the need for fusion was related to the 2002 injury.

Petitioner argues she proved that her condition has materially worsened requiring the fusion of her foot and she proved a current hip condition of ill being. She sites her testimony as well as the opinions of Dr. Holmes and Dr. Kudrna. In her brief, Petitioner does not seek prospective medical treatment or specify a recommended additional permanent partial disability award. In its brief, Respondent asserts that it has authorized the prospective surgery for "several years." That assertion appears to be corroborated by Petitioner's testimony that it had been authorized by insurance and Chubb, Respondent's workers' compensation insurance carrier, had authorized medication for her foot. In addition, her failure to refute Respondent's assertion is telling.

The Commission concludes that the award of additional permanent partial disability benefits is not appropriate here. First, Petitioner has not met her burden of proving she has a permanent hip condition of ill being that is associated with the initial foot injury. The most recent MRI suggests a CAM deformity, which is congenital in nature. In addition, Dr. Virkis is persuasive when he noted that by favoring her right foot condition, Petitioner's gait actually placed greater strain on her left hip rather than the right hip, militating against causation to an alleged condition of ill being of the right hip.

Second, any additional permanent partial disability award for the foot condition would be premature. Because additional surgery has been approved but not yet performed, Petitioner is not at maximum medical improvement. She would be at maximum medical improvement only after she has the surgery and associated rehabilitation, at which time her current impairment could better be determined. In addition, even if some other of Petitioner's symptoms are somehow related to her foot condition, the permanency of those possible aggravations cannot be properly assessed until treatment for her foot condition is completed. Accordingly, at this time, Petitioner has not proven she is entitled to relief pursuant to §19(h) of the Act and the Commission does not grant her petition.

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IT IS THEREFORE ORDERED BY THE COMMISSION that the Petitioner's Petition for Relief Pursuant to §19(h) is not granted at this time and ultimate determination is deferred until Petitioner has completed medical treatment and she has achieved maximum medical improvement.

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

DATED: AUG 27 2015

Ruth W. White

Charles J. DeVriendt

Joshua D. Luskin

RWW/dw
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46