STATE OF ILLINOIS)
) SS.
COUNTY OF McLEAN)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Kim Hartnell,
Petitioner,

vs. No: 09 WC 24716

17IWCC0482

JC Penney Corporation, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Respondent and Petitioner have sought timely review of the decision of Arbitrator Pulia, filed on February 25, 2016, following arbitration hearing on January 27, 2016. The Commission hereby modifies Arbitrator Pulia's decision as described below.

This matter was initially tried under §19(b) on September 10, 2010 by Arbitrator White. In her decision, filed November 2, 2010, she found causation between Petitioner's February 13, 2009 accident and her neuropsychological injury. Arbitrator White awarded temporary total disability benefits, medical expenses, and prospective treatment. Respondent did not seek review of this §19(b) decision.

In the decision now under review, Arbitrator Pulia found Petitioner to be entitled to temporary total disability benefits from September 11, 2010 through June 24, 2015 (an additional 249 and 4/7 weeks beyond the date of the §19(b) hearing). Arbitrator Pulia also awarded permanent partial disability compensation reflecting 30% loss of the person as a whole under §8(d)(2).

The Commission, after considering issues including causal connection, temporary total disability, and nature and extent of permanent disability, and being advised of the facts and law, finds that Petitioner has failed to prove entitlement to temporary total disability benefits beyond May 18, 2011. As discussed in detail below, the Commission finds that Petitioner by that date reached maximum medical improvement as to the injury sustained during her accident. Any symptoms or other ill-being reported or experienced thereafter are unrelated. Further, the Commission reduces the award of permanent partial disability to 15% loss of the person as a whole.

FACTS

A. Pre-§19(b) Background

Petitioner was working at her second job as a part-time retail clerk at Respondent, JC Penney, when she had her work-related accident. Her primary job was underwriter assistant at State Farm, where she began employment about several years prior. On February 13, 2009, while retrieving shoes for a customer, she fell off a ladder, a distance of 12 to 15 feet, onto a concrete floor and sustained a closed head injury. Thereafter, she developed symptoms of post-concussion syndrome, including nausea, blurred vision, dizziness, headaches, memory problems, and other difficulties.[1]

A brain MRI performed on February 19, 2009 was interpreted as showing non-specific white matter lesions of unclear significance. In early April 2009, she came under the care of neurologist Dr. Karyn Catt. Dr. Catt was familiar with Petitioner, having treated her in 2004 for complaints of migraines and right facial numbness. Dr. Catt compared a brain MRI taken in connection with that 2004 treatment to the February 2009 MRI. Dr. Catt determined that there were no significant changes between the two. Of note, on July 29, 2009, she wrote, "Nonspecific white matter lesions on MRI of the brain from February 2009, not significantly changed compared to 2004, most likely due to diabetes. It is not felt to represent demyelinating disease with the negative CFS analysis in 2004." (RX 7).

Dr. Catt referred Petitioner to Dr. Jospeh Alper, Ph.D., of Carle Clinic in Urbana for neuropsychological testing. Dr. Alper conducted tests over three days in August and September 2009. Dr. Alper noted that her test results suggested significant symptom magnification; however, he concluded that she was impaired and in need of treatment. His diagnosis was post-concussion syndrome with psychiatric features, including depression and anxiety, and higher level cognitive deficits. Dr. Catt reviewed Dr. Alper's findings, opined that Petitioner's ill-being was caused by the fall, and recommended prospective psychiatric treatment and psychotherapy. (RX 7).

In her §19(b) decision, Arbitrator White made favorable reference to Dr. Catt's and Dr. Alper's assessments of Petitioner. Arbitrator White found causal relatedness between Petitioner's fall and her "cognitive difficulties, memory impairment, daily headaches, depression

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[1] In late March 2009, Petitioner and her husband went on a vacation in Mexico. At the hearing before Arbitrator Pulia, Respondent submitted a print-out of comments and photos of this vacation that were posted to Facebook. (RX 4). This evidence apparently had not been presented to Arbitrator White.

and anxiety, as well as her post-concussion syndrome[.]" (Arb. White's decision at 5). Arbitrator White's award included prospective medical treatment in the form of "psychiatric therapy and medications and psychotherapy with biofeedback, as suggested by the neuropsychological evaluation [performed by Dr. Alper] and endorsed further by Dr. Catt…as well as ongoing treatment under Dr. Catt." (Arb. White's decision at 6).

B. Treatment and Assessments Post-§19(b)

Subsequent to the favorable §19(b) decision, Petitioner came to be treated and/or assessed by four services providers. These providers, and the approximate time spans of their interaction with Petitioner, are as follows: (1) Dr. Pamela Warren, Ph.D. of Carle Physician Group (April 2011 to June 2011); (2) clinical psychologist Wilma McLaughlin, M.A. of Agape Counseling (June 2011 to May 2012); Dr. Virginia Moody, M.D., of Central Illinois Psychiatric Associates (November 2011 to June 2012); and Dr. Alvin House, Ph.D., of the Illinois Department of Human Services (December 2011).

The records from these providers (with the exception of therapist McLaughlin of Agape Counseling) indicate a pattern of behavior from Petitioner wherein she would initiate treatment or entreat assistance from providers, only to abandon the relationship once it became apparent that the provider believed that Petitioner was not as disabled as she claimed (i.e., suspected malingering) or otherwise would not assist her in obtaining the result she seeks in her workers' compensation case (that result being an award of permanent total disability). The treatment with these providers is described below.

Dr. Pamela Warren, Ph.D.

For unexplained reasons, Petitioner did not return to Dr. Catt for ongoing treatment after Arbitrator White's §19(b) decision. She did not receive any treatment from anyone for 5 months after the decision. Eventually, Petitioner presented to Dr. Pamela Warren, Ph.D., to whom Petitioner had been referred. On April 5, 2011, in a "Workers' Compensation Psychiatric Diagnostic Evaluation" report, Dr. Warren discussed Dr. Alper's prior testing from August and September 2009. Dr. Warren wrote that Dr. Alper "completed a great deal of neuropsychological testing of which he noted that there were anxiety and depressive symptoms but also that there was a strong element of symptom exaggeration and potentially malingering occurring as well." (RX 3). As to Petitioner's cognitive functioning, the measure of memory impairment displayed at that time, about 7 months post-injury, was remarkable:

> Dr. Alper also stated that, while there were some mildly suppressed performance on measures of intellect, executive functions and some measures of language relative to an individual at her expected premorbid level of functioning, there were some moderate-to-severe impairments on measures of memory. The level of memory impairment would be more typical with an individual who has unambiguous degenerative dementia of the Alzheimer's type rather than mild traumatic brain injury.

(RX 3, 4/5/2011 at 3). Petitioner does not have unambiguous degenerative dementia of the Alzheimer's type (at least none alleged to be work-related). Dr. Warren noted that excellent recovery from an injury such as Petitioner's -- classified as a mild traumatic brain injury -- typically is obtained in 3 to 12 weeks. That Petitioner was producing these kind of test results 7 months post-injury suggested to Dr. Warren that her current dysfunction was not due to any physical trauma to the brain, but instead were indications of an affective disorder and deliberate "insufficient effort" on Petitioner's part during testing. As Dr. Warren continued:

> [M]ore telling is that the performances on symptom validity reflected an inability and [un]willingness to sustain effort to obtain a valid representation of her current cognitive potential. Dr. Alper noted that, in the absence of any objective evidence of a very unlikely preexisting dementia, the indications were of an affective disorder and insufficient effort that were related to the persistence of her symptoms. Dr. Alper noted that her medical records reflect a history of memory problems in response to stress and stress created by her head injury in her daily life appears to be a major mediating influence on her level of functioning.

(RX 3, 4/5/2011 at 3). Dr. Warren also noted, "Ms. Hartnell reports profound recent and remote memory problems. Again, this is typically inconsistent with a mild head injury, particularly when there is no objective medical evidence aside from some changes that were seen on an MRI but were later deemed to not be at the root of her memory problems in accordance with Dr. Joseph Alper and Dr. Catt.... Ms. Hartnell's judgment, intellectual level, and IQ, based on the answers given, were estimated to be within normal ranges." (RX 3, 4/5/2011 at 5).

On May 18, 2011, Petitioner underwent further psychological testing and scored high for malingering. At that time, Dr. Warren was of the opinion that Petitioner's issues were "far more likely" related to some underlying depression and anxiety disorder, as opposed to any type of brain injury or any sustained effects from the fall. Dr. Warren concluded that Petitioner "is likely to be greatly exaggerating any cognitive concerns that she has" and that she was engaged in "frank malingering." (RX 3, 5/18/11). Shortly after this testing, Petitioner stopped seeing Dr. Warren. Petitioner stated that she stopped seeing Dr. Warren because she felt Dr. Warren disliked her and her husband. (Tr. 71).

Wilma McLaughlin, M.A. and Dr. Alvin House, Ph.D.

Beginning in June 2011 and up through May 2012, Petitioner underwent counseling sessions with clinical psychologist Wilma McLaughlin, M.A., of Agape Counseling. Petitioner sought out this therapy on her own. Ms. McLaughlin noted diagnoses of major depressive disorder, cognitive disorder not otherwise specified, and post-concussion disorder with associated depression. Ms. McLaughlin's recommendations included evaluation by a psychiatrist for antidepressant medication and to seek assistance from the Illinois Department of Human Services, Office of Rehabilitation Services (DHS-ORS) for job retraining evaluation. (PX 3).

Pursuant to Ms. McLaughlin's recommendation, Petitioner contacted DHS-ORS to apply for job search and job retraining assistance. In connection therewith, on December 28, 2011, Petitioner underwent an interview and psychological testing conducted by Dr. Alvin House, Ph.D. Afterwards, Dr. House authored a psychological assessment report, which report is

notable for Petitioner's low scores of intellectual functioning. Startlingly, Petitioner's IQ tested at 79, which the doctor noted "falls in the borderline range of intellectual functioning." (PX 4).[2]

The Commission notes here that Dr. House's report, on its face, supports Petitioner's claims of significant cognitive deficits. However, when viewed in light of the test results that would be obtained a year later by Petitioner's own independent medical examiner, Dr. Steven Rothke -- Dr. Rothke tested her IQ at 102, or average -- the conclusion that Petitioner is engaged in purposeful symptom exaggeration is inescapable. (Dr. Rothke's examination is discussed in more detail below.)

At any rate, Dr. House recommended that he be given Petitioner's treatment records for review. He also recommended "helping Ms. Hartnell seek a relatively low stress position for at least the time being," as "she has good social skills and some experience in retail work, [and] possibly this could be used as a basis for re-entering employment." (PX 4). Petitioner did not follow through with DHS-ORS, which eventually closed her file for missed appointments. Petitioner claimed that she could not remember that she had appointments. (Tr. 74-76). Her husband testified that she could not make it to her appointments due to her severe headaches. (Tr. 46-47).

Dr. Virginia Moody, M.D.

Ms. McLaughlin also referred Petitioner to psychiatrist Dr. Virginia Moody. Petitioner treated with Dr. Moody from November 2011 through June 2012, receiving therapy and medication management. Petitioner reported sleep problems and anxiety, and displayed hypersensitivity to hearing, tactile, and visual stimuli. Dr. Moody also noted that prior psychological testing suggested that some of her dysfunction might be "due to anxiety or depression, and not completely due to underlying brain damage, such as Alzheimer's or tissue damage from the fall." Dr. Moody diagnosed generalized anxiety disorder and post-concussive syndrome. (PX 5).

Of note, Dr. Moody's records indicate that Petitioner was focused on her workers' compensation claim. On May 31, 2012, Dr. Moody wrote, "Court in June for benefits. I explained I cannot speak to her prior function or attribute current symptoms to accident because I was not treating her prior to accident. I can't speculate." On June 27, 2012, Dr. Moody wrote, "[Petitioner] tells me she's disappointed I'm not more cooperative with lawyer… I explained my response to lawyer that I can't make predictions or correlations he's asked for," and that Petitioner is "frustrated by me and work comp. claim." Petitioner made about one more visit to Dr. Moody and, as she did with Dr. Warren and Dr. House, stopped seeing this provider. (PX 5).

HEARING TESTIMONY

Before Arbitrator Pulia, Petitioner testified regarding her alleged ongoing constellation of disabling symptoms and their effect on her life. As corroborating witnesses, she called her husband, her daughter, and two longtime friends. The theme of Petitioner's and her witnesses'

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[2] At hearing, Arbitrator Pulia denied admission of Dr. House's records in to evidence, upon Respondent's objection. Dr. House's records are included in the transcript of hearing as the rejected exhibit, PX 4.

testimony is that, ever since her head injury, Petitioner has been a different person. According to this account, Petitioner pre-accident was highly social and outgoing, energetic, often planning social events with friends. But now she is depressed, anxious, fearful, avoids crowds, stays home a lot, and is socially withdrawn.

Petitioner's cognitive impairment includes problems with memory and executive functioning. She is easily confused, easily overwhelmed, cannot concentrate, cannot complete tasks, and is very forgetful. As an example of her impairment, it was related that if she starts in the kitchen to do dishes, and then goes to the laundry room, she will start doing laundry, but then she will see something that needs to go to the bathroom, so she will leave the laundry incomplete as well. (Tr. 37-39; 83). Her husband testified that she cannot manage the family's finances as she used to, because she forgets to balance the checkbook and their bank account gets overdrawn. (Tr. 19-20). On a typical day, she has "headaches, anxiety, some depression," but she will have "one or two" good days per week. (Tr. 84-85). Her chronic headaches or migraines can be triggered by noise and inclement weather, and are sometimes so severe she is unable to leave the house, not even to show up for work. (Tr. 47-48, 85-86). She has gotten lost while driving, and is comfortable driving only distances of 7 to 10 miles. However, occasionally, she will "get brave" and will drive to Bloomington, 15 miles away. (Tr. 86). Her husband bought her a new car in September 2013. (RX 8).

INDEPENDENT MEDICAL EVALUATIONS

Both parties presented the medical testimony of their retained experts, whose evaluations of Petitioner included interview and neuropsychological testing of Petitioner. These experts' findings and opinions are discussed below.

Dr. Steven Rothke, Ph.D.

On December 13, 2012, Petitioner was evaluated by neuropsychologist Dr. Steven Rothke, Ph.D., at her counsel's request. Dr. Rothke's diagnoses were depressive disorder and generalized anxiety disorder. As to causal connection between these diagnoses and her accident of February 2009, Dr. Rothke opined that there was none:

> Q: Is there any relationship between a head injury or any kind of specific trauma to the body that would have caused this depression and anxiety?
>
> A: No, the depression and anxiety are not – they can be; but, in her case, I don't think they are directly due to brain changes. Brain changes can affect the way emotion is expressed, but hers is what's called a reactive depression and a reactive anxiety.

(PX 2 at 58-59).

Regarding Dr. Rothke's neuropsychological testing, the results were remarkable for the mildness of any purported impairment in cognitive functioning. For example, in the Wechsler Memory Scale, 4th edition, a widely-used test of memory, Dr. Rothke found that Petitioner scored no worse than in the "mild or borderline impaired" range in some components of the test,

and even scored in the "average to high average" range on other components. (PX 2 at 25-27). There were no indications of any severe impairment on any component of any test. Petitioner often scored in the normal and average ranges, including on the Wechsler Adult Intelligence Scale, which indicated an average IQ of 102 (far higher than the score obtained by Dr. House just a year prior). (PX 2 at 21-22). Significantly, Dr. Rothke opined that, while Petitioner had memory difficulties, "they don't rise to a level that she can't function or couldn't learn to work around in somewhat, given the right interventions." (PX 2 at 27-28).

Of note, although Dr. Rothke avoided speaking of Petitioner in terms of "symptom magnification" or "malingering," even he was obliged to note that there may be an issue of "over-reporting" of certain symptoms. When asked to elaborate, he testified that he did not find indication of "overstatement of psychological or psychiatric problems." However, regarding "cognitive and somatic problems," Petitioner's score fell in "what's called the possible range of over-reporting." (PX 2 at 43-46). In other words, while Dr. Rothke did not question the sincerity of Petitioner's self-report of depression, anxiety, and other emotional distress, he acknowledged that she was exaggerating the nature and extent of her intellectual disabilities (such as memory problems) and her physical problems, i.e., her headaches.

Dr. Alexander Obolsky, M.D.

Respondent presented the medical opinion testimony of its §12 examiner, forensic psychiatrist Dr. Alexander Obolsky, M.D. Dr. Obolsky interviewed Petitioner in May 2013 and also administered an extensive battery of neuropsychological tests, including several symptom validity tests (designed to spot malingering) Dr. Obolsky's opinion was that Petitioner was malingering both her cognitive and emotional symptoms. He opined that, at worst, Petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her pre-existing level of functioning would have been 3 months post-injury. He opined that Petitioner's current mental health treatment was not related to her injury on February 13, 2009 and that she was mentally fit for full-time employment. (RX 1).

In both his written report and his evidence deposition, he pointed out that Dr. Alper and Dr. Warren both indicated the possibility of symptom magnification. Dr. Obolsky noted (as did Dr. Warren) that Dr. Alper discerned that Petitioner's memory impairment appeared to be on the level of someone with Alzheimer's. Regarding Petitioner's performance on the Green's Word Memory Test, administered by Dr. Obolsky's office, Petitioner's results were "worse than those individuals that experienced severe traumatic brain injury and were in a coma ...worse than people with severe depression ...worse than people with dementia." The forensic psychiatrist stated that "if you gave this test to children who have a very low IQ, they will perform better than [Petitioner] did." (RX 1 at 38-39).

Regarding Petitioner's emotional state at the time of her interview with Dr. Obolsky, it should be noted that she had recently lost her house in foreclosure and an adult son had died of a cardiac event. (RX 1 at 24-26).

VOCATIONAL ASSESSMENTS

Both parties also retained vocational rehabilitation experts. Petitioner's expert, Dennis Gustafson, opined that Petitioner was permanently and totally disabled from work because of her debilitating headaches, lack of focus, impaired memory and anti-social disorders. (PX 2). Not even Dr. Rothke believed that Petitioner was so incapable of employment. Mr. Gustafson, upon cross-examination, agreed that Dr. Rothke never stated that Petitioner could not work. (PX 2 at 49-50, 63-64).

Respondent retained Julie Bose as its vocational rehabilitation expert. Ms. Bose indicated that Petitioner was of average intelligence and had some mild deficit in memory and processing speed. Ms. Bose also noted that Dr. Alper, Dr. Warren, and Dr. Obolsky all questioned whether Petitioner's symptoms were exaggerated and whether the tests represented an accurate measure of her abilities. Ms. Bose opined that Petitioner would be employable in more unskilled, routine types of positions that do not require a high level of socialization and did not involve skilled and multistep tasks such as a housekeeping cleaner, a laundry worker, or a janitor. (RX 6). Arbitrator Pulia found Ms. Bose's opinion credible in her determination that Petitioner was no longer totally disabled as of June 24, 2015, the date of Ms. Bose's evaluation of Petitioner. (Arb. Pulia's decision at 25).

Regarding Petitioner's efforts to find employment, they have been unsuccessful to date. According to her husband, she had applied to employers including a gas station. However, no employer would call her back (even for unpaid volunteer positions) because Petitioner would be "truthful" to the potential employers when making employment inquiries, reveal that she had a head injury, and advise them that her migraines might prevent her from showing up for work. (Tr. 47-49). Petitioner even testified that her friends, owners of a local restaurant, had offered her a part-time job as a waitress. However, she declined this offer because symptoms of her condition -- her aversion to noise and crowds, and her frequent headaches -- would make her an unreliable employee. (Tr. 88-89).

DISCUSSION

A. The Arbitrator Erroneously Invoked "Law of the Case" Doctrine Regarding Causation

At the outset, the Commission notes that it is apparent that Arbitrator Pulia was invoking the doctrine of the law of the case in her summary disposition of the causation issue, where she wrote:

> This claim was previously tried pursuant to Section 19(b) of the Act on 9/10/10. One of the issues in dispute was causal connection. With respect to this issue, Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression, and anxiety, as well as her post-concussion syndrome are all directly related to her February 13, 2009 work related injury. Respondent did not appeal Arbitrator White's decision. Petitioner

> is not claiming any new injuries or conditions as a result of her work injury. As such, this arbitrator finds the conditions Arbitrator White found causally related to the work injury, are still causally related to the work injury.

(Arb. Pulia's decision at 18-19). Arbitrator Pulia then stated that she would proceed to "address whether or not the treatment petitioner has received for these conditions since the 19(b) hearing on 9/10/10 was reasonable and necessary, and the impact these conditions now have as they relate to the nature and extent of petitioner's injury." (Arb. Pulia's decision at 19).

The Arbitrator has erred insofar as she decided that the law of the case doctrine relieved Petitioner of her burden to prove, at the permanency hearing, that any purported ill-being as may be extant after the date of the earlier §19(b) hearing is causally related to her accident. The Commission is allowed in a subsequent hearing to find that a previously causally connected condition has resolved and to deny a current causal connection without reversing the prior §19(b) decision. *See Weyer v. Illinois Workers' Compensation Comm'n*, 387 Ill. App. 3d 297 (2009). Each §19(b) hearing is a separate and appealable proceeding, limited to a determination regarding the compensability of a claim up to the date of hearing. *See R.D. Masonry, Inc. v. Illinois Workers' Compensation Comm'n*, 215 Ill.2d 397 (2005). And while Arbitrator White's §19(b) decision became a final decision when not appealed, her causation finding regarded, and was limited to, Petitioner's condition *up to the time of the §19(b) hearing.*

Petitioner still had the burden of proving that her current ill-being, i.e., the ill-being as it was alleged to exist post-§19(b) and up to the time of the permanency hearing, was causally connected to her accident. The evidence shows that Petitioner has failed to carry her burden. The evidence presented at hearing showed that Petitioner is malingering and exaggerating her symptoms, in particular her cognitive problems. Extensive testing done by three doctors, including two of her own treating doctors (Dr. Warren and Dr. Alper), are consistent with symptom exaggeration and malingering.

The evidence shows that Petitioner's post-concussion syndrome and any other effects from her February 2009 fall resolved to the point of maximum medical improvement not long after the §19(b) decision. Specifically, maximum medical improvement as to her work-related condition was achieved no later than May 18, 2011, when Dr. Warren found evidence of "frank malingering" and concluded that Petitioner's dysfunction at that time was related not to traumatic brain injury but to underlying depression and anxiety. Petitioner's history since that day has further suggested the validity of Dr. Warren's assessment of malingering and symptom magnification.

B. The True Nature and Extent of Petitioner's Mild Disability Is Best Shown in the Testing Done By Dr. Rothke

Although Arbitrator White found that Petitioner suffered from compensable ill-being at the time of the September 2010 hearing, it should be noted that, as early as a year prior to that hearing, symptom magnification was an issue raised by Dr. Alper. It is true that Dr. Alper eventually made diagnoses and recommendations, endorsed by Dr. Catt, that Petitioner was impaired and in need of treatment. It is true that Arbitrator White cited Dr. Catt's opinions favorably in her §19(b) decision. And, as noted above, the Commission is bound by Arbitrator White's determination regarding the cause of Petitioner's symptoms up to that time. However,

post-§19(b), other providers and experts – including Dr. Warren, Dr. Obolsky, and even her own independent medical examiner, Dr. Rothke – have noted symptom magnification and malingering.

It should be borne in mind that symptom magnification and actual impairment are not mutually exclusive. "Failing" a symptom validity test only means that the true nature and extent of the individual's condition cannot be determined (by that test), since that individual has purposefully exaggerated or otherwise obscured her real condition. In the instant case, the Commission finds that Petitioner currently suffers some condition of impairment. However, when her condition is broken down into its constituent symptoms, the following conclusions must be made: (1) Petitioner's current emotional symptoms (depression and anxiety) are not related to any brain injury sustained on February 13, 2009; (2) her current physical symptoms (chronic headaches) are not related to any brain injury sustained on February 13, 2009 (and are likely being over-reported by her); and (3) her current cognitive impairment (memory problems and other difficulties with information processing) is mild and does not render her incapable of working. With regard to symptoms of cognitive impairment, these symptoms have been considerably exaggerated by Petitioner.

Ironically, these conclusions are supported by Dr. Rothke's findings. It is apparent that Petitioner made her most honest efforts when being tested by her own independent medical examiner. Regarding emotional symptoms, it does appear that Petitioner is mostly convinced of her extreme disability and experiences genuine distress from this conviction. However, as to cognitive disability, there is ample evidence that she had significantly exaggerated such limitations when being tested by all doctors other than Dr. Rothke. And even as to the tests administered by Dr. Rothke, yielding results of mild impairment at worst, Dr. Rothke was obliged to note "over-reporting" of cognitive difficulties.

Lastly, it bears emphasizing that not even Dr. Rothke believed that Petitioner was totally disabled. As he testified, Petitioner's mild memory difficulties were not so severe that she was rendered incapable of working in some capacity. The evidence shows that Petitioner's lack of success in finding employment is due to her own desultory job search efforts and self-defeating behavior. In short, Petitioner's alleged un-employability is illusory. Her stated desire to return to health and gainful employment is to be questioned. [3]

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 25, 2016 is hereby modified.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay Petitioner the sum of $ 482.63 per week commencing September 11, 2010 through May 18, 2011 (35 and 4/7 weeks), that being the period of temporary total incapacity for work under Section 8(b) of the Illinois Workers' Compensation Act. Respondent shall receive a credit of

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[3] At hearing, when asked whether she is asking the Arbitrator to find her permanently unable to work, she answered, "That's not my hope honestly, but I don't know what other choice I have, so it's not looking too good for the home team." (Tr. 89-90).

17IWCC0482

$19,305.20, that being the sum of temporary total disability benefits from September 11, 2010 through June 17, 2011, already paid.

IT IS FURTHER ORDERED BY THE COMMISSION that the Respondent shall pay the reasonable and necessary charges for medical services provided to Petitioner through May 18, 2011, subject to the limits of Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $ 434.36 per week for a period of 75 weeks, as the injury sustained caused permanent partial disability to the extent of 15% loss of use of the person as a whole under Section 8(d)2 of the Act.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $ 31,000.00. 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 - 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-06/06/17
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

HARTNELL, KIM
Employee/Petitioner

Case# **09WC024716**

JC PENNY CORP
Employer/Respondent

17IWCC0482

On 2/25/2016, 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 0.45% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0225 GOLDFINE & BOWLES PC
KEVIN ELDER
4242N KNOXVILLE AVE
PEORIA, IL 61614

5074 QUINTAIROS PRIETO WOOD & BOYER
MICHAEL SCULLY
233 S WACKER DR 70TH FL
CHICAGO, IL 60606

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

KIM HARTNELL,
Employee/Petitioner

v.

JC PENNY CORP.,
Employer/Respondent

Case # 09 WC 24716

Consolidated cases: _____

17IWCC0482

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **1/27/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **2/13/09**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$37,644.88**; the average weekly wage was **$723.94**.

On the date of accident, Petitioner was **51** years of age, ***married*** with **no** dependent children.

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

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

Respondent shall be given a credit of **$19,305.20** for TTD, **$00** for TPD, **$00** for maintenance, and **$00** for other benefits, for a total credit of **$19,305.20**.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the medical fee schedule, of $3,310.00 to Dr. Warren, $115.00 to Dr. Moody, and $835.00 to petitioner for out of pocket expenses, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $482.63/week for 249-4/7 weeks, commencing 9/11/10 through 6/24/15, as provided in Section 8(b) of the Act. Respondent shall receive credit for the $19,305.20 it has already paid.

Respondent shall pay Petitioner permanent partial disability benefits of $434.36/week for 150 weeks, because the injuries sustained caused the 30% loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

2/14/16
Date

ICArbDec p. 2

FEB 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

Petitioner, a 51 year old, retail clerk, sustained an accidental injury that arose out of and in the course of her employment by respondent on 2/13/09, when she fell off a ladder approximately 12 feet onto a concrete floor. This case was previously heard before Arbitrator White pursuant to Section 19(b) of the Act on 9/10/10. The issues in dispute were causal connection, medical, prospective medical, and temporary total disability. On 11/2/10 Arbitrator White issued her Arbitration Decision. Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression and anxiety, as well as her post concussion syndrome are all directly related to her February 13, 2009 work related injury. Arbitrator White found respondent shall pay reasonable and necessary medical services of $10,085.00, as provided in Section 8(a) of the Act; respondent shall pay petitioner temporary total disability benefits of $482.63/week for 81-6/7 weeks, commencing 2/14/09 through 9/10/10 as provided in Section 8(b) of the Act; that respondent is entitled to a credit of $31,370.95; and that respondent shall pay all reasonable costs subject to the Fee Schedule for the psychotherapy and psychiatry that Dr. Catt recommended.

On 4/5/11 petitioner underwent an evaluation performed by Dr. Pamela Warren, Licensed Clinical Psychologist. Petitioner was referred to Dr. Warren by respondent's insurance carrier nurse, based on Arbitrator White's order that petitioner undergo psychotherapy and psychiatry as recommended by Dr. Catt. Dr. Warren interviewed petitioner, took a medical history, education and social history, and performed a mental status evaluation. Dr. Warren's diagnostic impressions were:

AXIS I:
1. Rule out major depression disorder and any of the anxiety -spectrum disorders.
2. Rule out symptom exaggerations.
3. Rule out malingering.

AXIS II: Diagnosis deferred.
AXIS III: Please review Ms. Hartnell's medical chart for full medical disclosures.
AXIS IV: Social withdrawal and ongoing self-report of cognitive problems.
AXIS V: Global Assessment of Functioning: 60

Dr. Warren's treatment recommendation had been for cognitive-behavioral therapy, but she noted that it was also important, because of some of the issues raised, that petitioner was going to mostly likely need to complete some additional psychological testing. Dr. Warren noted concerns because petitioner had clear evidence of symptom exaggeration, and in some cases malingering with Dr. Alper, that an update of these tests would be dictated in another report.

On 5/18/11 petitioner underwent 145 minutes of psychological testing. For the total test, any score greater than 14 is indicative of malingering and petitioner's score was 26. The results showed that in multiple scales

petitioner was likely to be greatly exaggerating any cognitive concerns that she has. Evidence of frank malingering was also found. It was noted that these results were going to be reviewed at her next appointment. Dr. Warren was of the opinion that if petitioner has underlying depression it is far more likely that the issues are related to anxiety and depression as opposed to any type of brain injury and any sustained effects from the fall that she reported to have experienced.

On 11/8/11 petitioner first presented to Dr. Virginia Moody, at Central Illinois Psychiatric Associates, for medicine management and therapy. Petitioner followed-up with Dr. Moody on 7 occasions from 11/8/11-6/26/12. Petitioner paid for this treatment "out of pocket". On 11/8/11 Dr. Moody had petitioner take the Self Administered Gerocognitive Examination (SAGE). Petitioner provided Dr. Moody with a history of the injury on 2/13/09. She stated that she was unconscious for an unknown amount of time. Petitioner could not recall clear details of what happened and only remembered walking out of the stockroom and the customer being angry that it took so long. She stated that several days she developed post-concussive syndrome, and was referred, by her current neurologist, who she had been seeing for prior TMJ pain and migraine headaches, to Dr. Alper for a neurological testing. She reported that her cognitive deficits have not improved significantly, but her dizziness and headaches had improved somewhat. She reported significant anxiety with catastrophizing ideations, when she feels she is not contributing to the family. She stated that too noisy environments cause her to shut down. She denied panic attacks, specific phobias, or PTSD. She stated that she felt avoidant of people, because they will notice her deficits and judge her. She denied any past psychiatric history, but Dr. Moody noted that a review of her records showed that she had been on Cymbalta, and perhaps Celexa and Ambien. She stated that she takes Maxalt for her migraines. She stated that her headaches have improved somewhat since the initial trauma.

Following her examination Dr. Moody diagnosed that petitioner was suffering a significant degree of anxiety; displaying some difficulties with hyper-sensitivity of hearing, tactile and visual; post-concussion syndrome; and has some difficulties with memory and judgment. Dr. Moody noted that prior psychological testing indicated that some of petitioner's dysfunction might be due to anxiety or depression and not completely due to her underlying brain damage, such as Alzheimer's or tissue damage from the fall. Dr. Moody diagnosed Generalized Anxiety Disorder, Post-concussive Syndrome, Financial and ADL difficulties, and GAF+35. Dr. Moody did not know if petitioner could handle finances. She noted that petitioner is capable of handling most, if not all in-house ADL's, and has some limited function in the community, due to restrictions on her driving and getting lost when she leaves her home at times. Dr. Moody recommended a trial of Gabapentin for sleep.

On 11/12/11 Wilma McLaughlin, MA, LCPC, and petitioner's counselor at Apage Counseling, drafted a letter to petitioner's attorney, Kevin Elder, regarding her observations and professional opinion related to petitioner. McLaughlin noted that she had seen petitioner 6 times for individual psychotherapy from 6/30/11 through 11/3/11. She noted petitioner's presenting concerns were loss of cognitive function and depressive symptoms since suffering a fall from a ladder in February 2009. Petitioner reported that prior to the fall she had been an outgoing, confident and social individual; worked five years at State Farm Insurance with increasing degrees of responsibility and multitasking as part of her position; and full time before that for a number of years elsewhere. These statements were corroborated by her husband, Chris Hartnell. Petitioner reported that since the fall she has experienced difficulty focusing and staying focused, is highly anxious when in crowds or social situations, cannot multitask, is forgetful, has difficulty with memory retrieval, has difficulty with simple tasks, easily gets overwhelmed and confused, and believes her judgment is at times unsound. Petitioner also reported that she easily fatigues, has difficulty sleeping, and has had an increase in the frequency and severity of headaches since the fall. McLaughlin noted that petitioner's goals were to return to some kind of gainful employment and be able to function more fully in household tasks and socially. McLaughlin recommended that petitioner consult with a psychiatrist for a medication evaluation and apply for services from the Department of Rehabilitation Services of the Illinois Department of Human Services. She also instructed her to complete a daily mood log and provide it to her each week. McLaughlin noted that petitioner followed her recommendations. In conclusion, McLaughlin was of the opinion that based on petitioner's presentation, self reporting, corroborating statements by her husband, and medical records substantiating a closed head injury, i.e., concussion, she assigned the diagnosis of Cognitive Disorder Not Otherwise Specified; Post-concussional Disorder with associated depression. Her treatment plan was for petitioner to alleviate symptoms of depression through cognitive behavior intervention and referral for psychiatric evaluation for possible medication intervention.

On 12/13/12 petitioner underwent a Section 12 examination performed by Dr. Steven Rothke, a clinical psychologist with a subspecialty in neuropsychologist, at the request of her attorney. In addition to his interview and testing of petitioner, Dr. Rothke spoke with her husband, Chris Hartnell. Dr. Rothke also reviewed medical records sent to him by petitioner's attorney that included records from Bromenn Healthcare, OSF St. Joseph Medical Center, Carle Clinic, the Illinois Department of Rehabilitation Services, Central Illinois Psychiatric Associates, and an independent medical exam by Dr. David Gelber. Dr. Rothke opined that the majority of the diagnostic tests of petitioner's he reviewed were largely negative. Dr. Rothke testified that during his interview of petitioner there was not anything significant in her past that he thought was having an impact on her current condition. However, he did learn some issues in her background that might make her more susceptible to the

effects of future trauma, including the emotional abuse by her first husband, and the fact that she was adopted at the age of nine. Dr. Rothke noted that when he tested petitioner she showed some improvement in her attention and concentration, and effort, as compared to when she was tested a year prior.

Dr. Rothke summarized that the results of the two Wechsler tests support some memory difficulties, and that they did not rise to a level that she could not function or could not learn to work around in some way, given the right interventions. With respect to the Stroop test, petitioner performed in the low average range as it applies to performing tasks or multi-tasking. Dr. Rothke opined that it is extremely unlikely that petitioner's Stroop test results would have been the same before the accident, because he did not believe petitioner could have held down two jobs if the results were the same. Dr. Rothke opined that when looking at both the Grooved Pegboard test and the Trail Making test, which also looks at visuomotor speed, that petitioner's sequencing ability was good and intact, which was good with respect to her driving ability. He opined that although her motor ability seemed to be impaired, some of it could be related to the right arm injury she sustained at the time of her fall. He opined that motorically, petitioner was slower than she probably was in the past, beyond any effect of aging. On the NAB Mazes Test and NAB Categories test, Dr. Rothke opined that petitioner performed in the average range for women of her age and level of education. He found no deficiencies. He further opined that this means that petitioner is able to still think in concepts, can think abstractly at least at an average level, and can be adaptive in coming up with solutions to tasks that are not typical everyday tasks. Dr. Rothke opined that on the Clock Drawing Test, that looks at planning, judgment, and spatial reasoning, petitioner's spatial reasoning was good. He also opined that the Famous Faces test, is usually not affected by the kind of injury that petitioner had. He opined that petitioner did well on this test. On the BHI-2 Test, that looks at the extent of pain someone is experiencing in different regions of the body, psychological reactions to pain or functional limitations, and role of pain or physical limitations on physiological status, Dr. Rothke opined that petitioner showed the profile of an individual who likely, at least to some degree develops physical problems in response to stress, as well as feelings of helplessness and powerless to change her current circumstances and difficulty coping with stress. On the MMPI test, petitioner's findings were similar to those on the BHI-2 test. It showed that petitioner was very worried about her overall health and physical functioning; experiences difficulties with memory and concentration, anxiety and obsessive worrying; and often worries about her finances and loss of job. He opined that petitioner is prone to developing physical symptoms in response to stress. He also opined that the results show she has lost or has low self confidence, is feeling helpless in terms of making changes in her life and more introverted and shy than she was in the past, and is somewhat passive and has difficulty directly expressing feelings of displeasure or anger. Overall though, Dr. Rhotke opined that petitioner may have some over-reporting of cognitive and somatic difficulties (physical problems).

Based on all the records he reviewed, and the results of all the tests he performed, Dr. Rhotke's diagnoses were major depressive disorder, moderate and generalized anxiety disorder. He opined that these diagnoses are in response or reaction to the accident of 2/13/09, and in response to the subsequent difficulties she has had since that time. Dr. Rhotke opined that petitioner had not yet reached maximum medical improvement. He recommended an updated psychiatric consultation to evaluate medications for her depression, anxiety, and sleep disruption. He recommended a more active course of individual rehabilitation psychotherapy specific to working with an individual who has had an injury or a disabling condition. He recommended treatment with a rehabilitation psychologist. He agreed that counseling can be a form of psychotherapy. He recommended that she engage in volunteer work to give her life some structure so she is not just sitting at home. He noted that this would provide activity to organize he life around, and get her back into somewhat of a work routine. He was of the opinion that this would combat social isolation, enable her to do things that are useful to other people and improve self-esteem, and rebuild or sharpen skills that could eventually be applied to some form of gainful employment. Dr. Rhotke's last recommendation was that after she underwent the recommended psychiatric and psychological care, she should work with a vocational rehabilitation counselor to help her put a resume together, do a job search, learn how to interview and deal with questions of why she has been out of the workforce for four years.

On cross-examination Dr. Rhotke believed Dr.Moody was primarily providing medication management, and Wilma McLaughlin, the Counselor was performing psychotherapy. Dr. Rhotke testified that "The occurrence of the accident was very upsetting; so her depression and anxiety is her reaction to the accident, itself, and, more importantly, what it led to, whatever functional or physical problems she had that led to her inability to return to work, to pain, to distractibility and thinking difficulties." He testified that the difficulties stem from the accident, and that is what she is reacting to. He opined that this is what the depression and anxiety is in response to. Dr. Rhotke opined petitioner's depression or anxiety are not directly due to brain changes. Dr. Rhotke opined that petitioner's depression and anxiety had been present for the majority of time from the date of accident until his examination , and probably got somewhat worse over that time, in part due to her difficulties, her failure to return to work, and her financial difficulties. He further opined that depression can wax and wane depending on what else is going on in her life, or dependent on what treatment she is getting. He noted that petitioner had no problems performing the computer part of the testing.

Dr. Rhotke acknowledged that Dr. Alper performed some of the same testing in 2009 that he performed in 2012, and found that petitioner was possibly malingering and had symptoms of magnification. He believed that Dr. Alper believed his assessments and impressions did not give an accurate picture of petitioner's strengths and

weaknesses. He noted that Dr. Alper indicated that petitioner was unable to sustain consistent attention and effort, which is needed for an accurate picture of somebody. Dr. Rothke opined that his findings/opinions in 2012 more accurately portray her current functioning, than those of Dr. Alper in 2009. Dr. Rhotke opined that some of her results could in part be based on the fact that she was not working or not performing a function or volunteering when she was examined. Dr. Rhotke noted that petitioner reported that on a day to day basis she does light cooking, laundry at home, grocery shopping, and drives.

On 6/27/12 petitioner last followed-up with Dr. Moody. She reported that her headaches were worse, and that made her feel more depressed. She stated that her sleep was off, and she had decreased energy. Petitioner told Dr. Moody that she was disappointed that she was not more cooperative with her lawyer. Dr. Moody told petitioner and her lawyer that she cannot make predictions or correlations her lawyer asked for. Dr. Moody stated that she does not want to do depositions. Dr. Moody noted that petitioner told her she was frustrated with her and her worker compensation claim. Dr. Moody recommended that petitioner discontinue Gabapentin and consider another drug. Dr. Moody noted that if petitioner decides to transfer care she would forward her records.

Petitioner offered into evidence her Job Search records that included 3 or 4 applications. These included an Application for Employment to Funks Grove Library. The date she completed it was left blank. Petitioner also completed and withdrew her submission to Teltech for a Customer Service Representative. She also applied for a Customer Service Representative at Randstad, and Assistant Store Manager at Family Dollar.

On 5/24/13, the evidence deposition of Dr. Rothke was taken at the request of the petitioner. The vast majority of Dr. Rothke's work involves individuals who have sustained some type of injury or disabling condition, most commonly individuals with a head injury. He spends the majority of his time performing evaluations and consultations. Following the evaluation/consultation Dr. Rothke then makes referrals based on that treatment plan. Dr. Rothke is not a medical doctor. Psychologists are eligible for consulting privileges. Dr. Rothke testified that he does most Section 12 evaluations for the respondent.

On 10/14/13 Dr. Alexander Obolsky drafted a report regarding his forensic psychiatric evaluation, performed at the request of the respondent. The evaluation was performed in order to assess petitioner's reported mental health consequences of the fall on 2/13/09. The forensic psychiatric evaluation was comprised of a record review, forensic psychiatric interview, forensic psychological and cognitive testing, and data analysis. Dr. Obolsky reviewed records from Bromenn Healthcare Emergency Room, Carle Clinic, Mayo Clinic, Digestive Disease Consultants, Dr. Gelber, Health Direct, Dr. Catt. Dr. Frank, Dr. Moody, Health and Law Resources, Dr, Bailey, and Wilma McLaughlin, for treatment both before and after the injury on 2/13/09. Based on the evidence and his reasoning, Dr. Obolsky opined that petitioner was malingering her cognitive and

emotional symptoms and had reached MMI in May of 2009. He opined that petitioner is mentally fit for full time employment. He found no evidence of any impairing mental condition and was of the opinion no mental health treatment is required. Dr. Obolsky opined that petitioner's current mental health treatment is not related to her injury on 2/13/09. He opined that at worst, petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her pre-existing level of functioning would have been 3 months.

Dr. Obolsky found it significant that following the injury petitioner made several visits to the mall and reported lack of avoidance, anxiety, or emotional distress when exposed to reminders of her fall. He opined that this indicates that she did not develop posttraumatic stress disorder. He also found it significant that in August of 2009, when she underwent neuropsychological testing, she exhibited memory impairment as severe as that seen in Alzheimer patients, and inconsistent effort on several cognitive tests. He noted that Dr. Alper found petitioner did not put forth the best effort. Dr. Obolsky saw this as indicative of purposeful behavior to present oneself as being sick. Dr. Obolsky believed petitioner's trip to Mexico in October of 2009 and her ability to enjoy herself as documented in Facebook posts were discrepant with her complaints to various physicians before and after the trip. (The Arbitrator notes that Petitioner's trip to Mexico was on 3/28/09, and not in October of 2009, as verified by her passport.) Dr. Obolsky also relied on the opinions of Dr. Bhosale in November of 2009 when he reported "It is also apparent to me that the patient and her husband are grappling with having difficulty accepting the fact that her symptoms are not related to any structural or physiological injury to the brain. They are less inclined to believe this is all a psychological issue." He noted that Dr. Bhosale believed petitioner's cognition was intact, and that "he is not completely convinced the patient meets criteria for major depression and anxiety disorder." Dr. Obolsky was also of the opinion that Facebook posts with petitioner having drinks at a bar on 12/7/09 contradict a diagnosis of depression and anxiety. He further opined that her ability to enjoy herself with friends and on vacation disproves the presence of a current disorder. Dr. Obolsky also relied on Dr. Frank's opinion that petitioner's current examination was "entirely within normal limits," that she has a lot of subjective complaints," and appeared to have some somatoform type of disorder in 2004. He also relied on Dr. Frank's opinion that he could see no reason that petitioner could not function in her previous capacity working with computers and with the telephone at State Farm.

Dr. Obolsky also relied on the opinions of Dr. Warren on 5/18/11, that showed petitioner purposely feigned cognitive and emotional symptoms. Whereas, Dr. Obolsky was of the opinion that Dr. Rothke's opinions that petitioner's reported symptoms "suggest" authenticated major depression and generalized anxiety disorders causally connected to the work event on 2/13/09, and authentic cognitive complaints, were in contradiction to the totality of the available data. Dr. Obolsky also found it significant that petitioner was

frequently non-compliant with prescribed treatment, in that she missed 2/3 of her physical therapy appointments. He found such behavior inconsistent with factitious disorder.

After reviewing petitioner's medical records that preceded the accident, Dr. Obolsky's opined that petitioner did not have a prior head or brain injury, but an MRI on 6/11/04 showed white matter lesion on her brain. Additionally, before her injury, petitioner treated for chronic migraines and headaches, as well as chronic pain in her neck and head. No mental, emotional, or cognitive deficits were noted before 2/13/09.

Dr. Obolsky opined that there is no objective evidence to support petitioner's complaints of cognitive pathology. He found solid evidence that petitioner purposely feigns cognitive deficits and symptoms of emotional distress. He opined that the results of the forensic psychiatric evaluation show that petitioner is malingering both her cognitive and emotional symptoms, psychological dysfunction, mental and physical symptoms, moderate depression, and self reported anxiety.

Dr. Obolsky opined that his diagnosis of malingering is robust and extensive and was based in part on the course, severity, and nature of the alleged symptoms are inconsistent with the nature, severity, and duration of the reported 2/13/09 work event; the course, severity, and nature of the alleged symptoms are inconsistent with petitioner's pre-morbidity history; discrepancies between test data and observed behaviors; discrepancies between various test data and known patterns of brain functioning; discrepancy between self-reported symptoms and observed behaviors; discrepancy between self-reported symptoms and evidence from non-clinical sources; evidence of exaggerated distress on various tests of psychological function; and multiple tests indicating that petitioner malingered emotional and cognitive symptoms.

On 3/13/14 the evidence deposition of Dr. Obolsky, board certified in general and forensic psychiatry, was taken on behalf of the respondent. Dr. Obolsky testified that his areas of expertise are the emotional, cognitive and mental consequences of severe emotional and physical injury to individuals. He opined that petitioner's complaints of mental symptoms are not related to the work event of 2/13/09. He opined that the treatment provided was reasonable as to the degree that the treating physicians and other professionals were not aware of the fact that petitioner was malingering her symptoms. He further opined that no treatment provided subsequent to the first three to four months after the injury was related to the injury on 2/13/09. He found it significant that two months before her appointment with him, her 31 year old son died in his sleep due to myocardial infarction. He also found it significant that when he talked to her about the fall she demonstrated no evidence of any emotional distress, but did demonstrate emotional distress when talking about her finances and where she was going to live. Dr. Obolsky opined that as of the date he examined petitioner she was mentally fit for full-time competitive employment consistent with her education, skills and experience.

On cross-examination, Dr. Obolsky testified that Dr. Rothke is not a physician. He also testified that Dr. Rothke did not address the issue of malingering. He opined that the published ethical guideline is that no neuropsychological testing can be done without a thorough evaluation of a person's effort and exaggeration of symptoms. He opined that neuropsychologists in the U.S. have different specialty-specific guidelines as to how to evaluate patients, which is different than that of physicians. Dr. Obolsky testified that when Dr. Alper compared the results of one or more testings of petitioner to that of somebody that had a degenerative dementia of an Alzheimer type rather than a mild traumatic brain injury, Dr. Obolsky was of the opinion that moderate to severe memory impairment is the definition of moderate to severe Alzheimer's. Dr. Obolsky did not diagnose Alzheimer's for petitioner. Dr. Obolsky testified that 99% of his worker's compensation cases are referred to him by insurance companies.

On 4/15/15 petitioner underwent a Vocational Assessment performed by Dennis Gustafson, M.S. CRC., at the request of petitioner's attorney, Kevin Elder. This assessment included education and work history, a review of medical information relative to the work related injury on 2/13/09, face to face interview with petitioner performed on 9/8/14, and a 20 minute telephone conversation with Chris Hartnell, petitioner's husband. Gustafson noted that petitioner exhibited a great deal of difficulty remembering prior jobs and dates of employment, and transitioning from one answer to the next during the interview. Petitioner told Gustafson that she was unable to focus on more than one thing at a time, and if she does not complete a task before going on to another task she forgets to return and finish it. She complained of headaches on 6 days of the week, with them being most severe on 2-3 days and she must lie down in a darkened room. She told Gustafson that the more severe headaches have improved over time. She reported that she could not recall how to use Microsoft Office, despite having successfully completed the computer testing done by Dr. Rothke. Chris Hartnell reported that petitioner can no longer multitask, and does not remain focused. He said it appears that she lost all her knowledge of insurance, and computer knowledge, despite Dr. Rothke's finding to the contrary. He noted that she is frustrated and depressed on a daily basis over her inabilities and suffers considerable social anxiety. He noted that petitioner has a fear of interstate driving, and exhibits high anxiety with the proximity of trucks or other large vehicles. Mr. Hartnell told Gustafson that he did not believe petitioner could work even in a simple job due to her focus concentration and memory issues, and if she did work she would miss 2-3 days per month due to severe headaches and anxiety.

Based on his interview with petitioner and her husband, and his review of petitioner's medical records that included Dr. Rothke's neuropsychological evaluation, labor market survey done by Coventry Worker's Compensation, SSDI award letter, Gustafson concluded that petitioner is unable to meet the productivity

requirements and overall employment expectation of any employer in any job as normally performed within the economy. He noted that this is the reason she was awarded SSDI. Gustafson was of the opinion that nothing seems to have improved with petitioner in the 2 years since her neuropsychological evaluation with Dr. Rothke, and may have worsened. Gustafson noted that petitioner tried to attempt volunteer work at Bromenn, but her failure to perform the expected requirements of the job resulted in further reduction of her self-esteem and sense of competency. He was also of the opinion that her inability to perform simple clerical tasks clearly points to the expectation that she would be unable to meet the more rigorous and detailed demands of her prior State Farm job or any other clerical type task consistent with prior work experience. He opined that her prior expertise in customer service was unlikely unable to be used for employment based upon current social anxieties and tendency toward people avoidance. Gustafson also ruled out repetitive task jobs because of petitioner's wandering focus of attention , and inability to efficiently mow her yard, which is a highly repetitive and simple task. Gustafson was of the opinion that petitioner was incapable of productive performance in any current job situation as normally performed. He also believed petitioner would not be a successful candidate for either further vocational education/training or vocational rehabilitation services.

On 6/24/15 petitioner underwent an Initial Vocational Rehabilitation Evaluation performed by Julie Bose, M.S.CRC at Medvoc. Ms. Bose received the file of petitioner for a limited assignment, to conduct a file review and vocational rehabilitation assessment. She reviewed numerous documents including vocational assessment conducted by Gustafson, neuropsychological examination by Dr. Rothke, neuropsychological evaluation from Dr. Obolsky, psychiatric records from Dr. Moody, neuropsychological evaluation from Dr. Warren, neuropsychological evaluation by Dr. Alper, and facebook entries from petitioner. Bose collected Behavioral/Biographical Data, Medical Data, Vocational History, and Current Vocational Rehabilitation Status from petitioner. Based on this information Ms. Bose made her rehabilitation impressions and recommendations. She noted that petitioner was of average intelligence and has some mild deficit in memory and processing speed. However, she also noted that Dr. Alper, Dr. Warren, and Dr. Obolsky all questioned whether petitioner's symptoms were exaggerated and whether the tests represented an accurate measure of her abilities.

Bose found no medical or psychological opinions that petitioner was permanently and totally disabled from work. She noted that petitioner's neuropsychological testing only reflects minimal deficits which should be factored into her vocational plan. Based on petitioner's self-reported activities of daily living, results of neuropsychological testing, and review of petitioner's presentation on social media, Bose was of the opinion that petitioner would be a candidate for a wide range of simple unskilled occupations. She was of the opinion that given petitioner's difficulty with coping with stress, she would not recommend that petitioner be placed in a job

with rigid production rates. Also, given petitioner's concern about the ability to interact appropriately on a social basis, Bose recommended that petitioner search for employment with limited social interaction. Bose was also of the opinion that petitioner would be an appropriate candidate for jobs such as that of a janitor, housekeeping cleaner, or laundry worker. She noted that these positions are self to moderately paced, involve no tandem work with co-workers, and are simple and routine in nature. Bose pointed out that the records reflect that petitioner also has poor self-esteem, and that reentry into the workplace would be helpful in improving her self-esteem, and making her a productive member of society.

On 8/17/15 the evidence deposition of Gustafson, was taken on behalf of petitioner. He believed petitioner was making an effort to respond to what he was asking her during her interview. He noted a lot of problems in petitioner's focus and general understanding of what was going on during the interview. Gustafson testified that petitioner worked as a receptionist and performed clerical work in a doctor's office, OSF Healthcare, and Mitsubishi for 10 years, and did customer service work on the phone at State Farm and eventually worked her way up to underwriter assistant with State Farm, performing clerical support to underwriter. Gustafson testified that petitioner told him she only volunteered at Bromenn for 4 hours every two weeks, but had a great deal of difficulty remembering when she could go back, how to access the info on the computer, or the duties she was to perform. He noted that she developed a feeling of being uncomfortable and anxious in an environment where a lot of people were present, and this caused additional headaches. Gustafson was under the belief that the injury caused her headaches. He did not believe she had migraines and had not been diagnosed with them. However, petitioner's medical records prior to her work injury showed that petitioner had severe migraine headaches and facial numbness as far back as at least 2004. Gustafson testified that he relied only on Dr. Rothke's recommendations that included deficits in new learning and recall of verbally and visually presented information; mental efficiency; visual motor speed; and right handed manual dexterity when he determined that she was unable to meet productivity requirements and employment expectations of any employer in any job. He did not believe vocational retraining would work due to her memory deficit, and was of the opinion that new learning would be needed and she has problems learning things. Gustafson agreed that Dr. Rhotke did not give petitioner any formal restrictions.

On cross-examination Gustafson testified that 99% of the workers' comp work he does is for petitioners. He testified that he only does evaluations. He does not do job placement. Gustafson testified that the only medical records he reviewed with respect to petitioner were the records of Dr. Rothke, the doctor petitioner's attorney sent her to. He testified that he did not review the records of Dr. Warren, Dr. Alper or Dr. Obolsky, all of which showed symptom magnification and malingering. He also did not review any of her treating records,

or social media, that showed some malingering, and petitioner in Mexico and in a bar with a group of friends having a great time, respectively. Gustafson attributed the symptom magnification that Dr. Rothke found to petitioner' s anxiety. He testified that it was his understanding that petitioner's forgetfulness, memory problems, and stress at work did not occur until after her injury. He was not aware that she had headaches and treatment for her headaches prior to the injury. He also did not know when petitioner voluntarily left her employment with State Farm, she was asked to leave, or left because she was moving from Bloomington. Gustafson admitted that he has no training in neuropsychological testing. He also agreed that Dr. Rothke never said petitioner could not work. Gustafson was of the opinion that because of petitioner's cognitive problems, she would likely fail at work and that failure would exacerbate her depression and anxiety. He noted that petitioner never looked for any work after leaving State Farm, but attributed it to her cognitive problems, even though some of those issues resolved over time.

The evidence deposition of Bose was taken on behalf of respondent on 9/28/15. Bose has been a certified vocational rehabilitation counselor for 32 years. Bose testified that she has a background in neuropsych training, as it relates to a semester long three-hour credit class in neuropsych assessment while in her master's degree program. She also worked as a contract provider for New Medico doing job placement. Bose does a wide variety of tasks that include medical management, creates vocational rehabilitation plans, coordinates training programs, performs job placement services and labor market surveys, performs ergonomic studies, and a fair amount of supervision of staff. Bose performs these activities on behalf of both the petitioner and respondent.

Bose testified that petitioner was late to her appointment because she was in a minor traffic accident on her way to see her. Petitioner drove herself to the appointment. Bose testified that she did not see petitioner's slow responses to be based on anything that she saw in the records from the neuropsych assessment. She attributed petitioner's slow response to her being rattled after having the traffic accident and being pretty shook up. She believed petitioner's response was more of an emotional response than a brain injury response. Bose noted that Dr. Alper felt that petitioner's sensory perceptional and motor functions were all predominantly normal, that she had an average IQ, and that her memory test, although reduced, was an underestimation of her true potential, that she had mild impairment in processing speed, and that her verbal ability was average. She further noted that Dr. Alper, based on validity testing, was of the opinion that there were inconsistencies in petitioner's responding, in both verbal and nonverbal measurements of domain. She noted that Dr. Alper was of the opinion that petitioner had some mild abnormalities, but did not feel that they were consistent with a brain injury, but rather more consistent with depression and anxiety. Bose noted that Dr. Frank indicated that

petitioner was already diagnosed in 2004 as having some type of somatoform disorder, and was of the opinion that petitioner could go back to work at State Farm. Bose also noted that Dr. Warren was of the opinion that petitioner gave poor effort on the TOMMS test, questionable engagement in the VSVT assessment, malingering range on the SIMS test, and basically concluded that petitioner's symptoms appeared to be more due to anxiety and depression than a brain issue. Bose noted that when petitioner saw Dr. Moody her complaints were more headache related than specific symptoms of TBI and anxiety and depression. She further noted that Dr. Moody indicated that petitioner reluctantly agreed to take the psychotrophic medication, but there was limited success. She noted that Dr. Moody also indicated that petitioner appeared to be preoccupied with the headaches, negative thinking, and eventually petitioner just discontinued treatment with Dr. Moody. She noted that Dr. Rothke diagnosed a mild impairment based on an average IQ, high average of attention span for digits and math, average recall for basic personal information and current events, mild impairment in immediate recall and call processing speed, and mild limitations. She noted that Dr. Rothke recommended that petitioner undergo voc rehab services and volunteer work because petitioner had some issues regarding self-esteem as well. She noted that the results of Dr. Obolsky's testing were consistent with those of Dr. Alper and Dr. Warren, who also noted malingering.

Bose testified that petitioner told her that most activities she could not do were limited primarily by her headaches, which she had prior to the work injury. She testified that petitioner was not under any current medical care and was not taking any medications for her headaches. She testified that petitioner told her she was treating her headaches with fountain Dr. Pepper, and it had been somewhat successful. Bose testified that petitioner told her that most of her problems driving, and her ability to socialize were caused by her headaches.

Bose testified that petitioner told her that she had not been looking for work because she believed she would not be able to be productive or reliable, primarily due to the headaches. Bose opined that petitioner would be employable in more unskilled routine types of positions that don't require a high level of socialization and positions that did not involve skilled tasks and multistep tasks such as that of a housekeeping cleaner, a laundry worker, or a janitor. She opined that a return to work could also be beneficial for her in terms of self-esteem. She opined that it would have been more beneficial if petitioner had attempted to return to work instead of trying a volunteer position.

On cross-examination, Bose opined that it would have benefitted Gustafson to review Obolsky's neuropsych report, Warren's neuropsych report, Alper's report, and review the actual test results, which were an objective measure. She noted that in all of them there was consistency with intellectual functioning, consistency in the area in the resting where there was impairment between all 3 of them, and consistent findings of

malingering or concerns about validity in all three of them. She also believed there was benefit to reviewing the neuropsych eval performed by Dr. Rothke.

Bose testified that she did not speak to petitioner's husband. She testified that when working with a person with a disability, she looks at the physicians restrictions to determine their work abilities, and none of the doctors opined that petitioner was unable to work, although some thought certain restrictions would be necessary.

On redirect examination Bose testified that the neuropsychologists did not feel that her mild impairment shown on testing was related to a brain injury, but was related to depression and anxiety, which no doctor opined was related to her fall at work.

Prior to petitioner's injury on 2/13/09 petitioner treated at Carle Clinic. In April of 2004 petitioner treated for numbness to the right side of her face, and her head. She reported that the "top of head hurts bad!" She was diagnosed with migraines and face numbness. It was also noted that petitioner had a history of migraines, unilateral face numbness, and focal symptoms. An MRI of the brain was ordered. She went to a neuro in May of 2004, who reviewed her extensive old records and noted that he needed her actual MRI brain films. Very small WM lesions were seen. In June of 2004 she was scheduled for a TEE for her facial numbness. The TEE showed a slight leaky valve, which was nothing to worry about, and was not causing her symptoms. Petitioner was prescribed Topamax.

In July 2004 petitioner told her doctor that her headache was not a problem at that time and she would rather not take any medication since it is a problem for her to remember to take the medication. On 7/27/04 petitioner reported that she "is like in a fog," "not understanding things that are going on, and has been this way for at least 4 days." Petitioner was scared about symptoms she was experiencing. "Feels out of it." She complained of dizzy, blurred vision. She said she was taking Tylenol 1500mg daily for pain at the base of her skull. On 9/3/04 she underwent a spinal fluid test. No sign of multiple sclerosis was noted. On 9/24/04 it was suspected that she had occipital neuralgia. On 10/12/04 she complained of left jaw, neck and shoulder pain, and pain burning at the base of her skull that radiates to the left jaw, neck and shoulder for the past 8 years. She stated that she was extensively evaluated at Mayo for these conditions, and the pain was felt to be related to facial pain of unknown etiology. Petitioner underwent some injections that provided no relief for her headaches. Dr. Catt felt there could be some occipital neuralgia or irritation of the occipital nerve contributing to her discomfort.

On 1/10/05 petitioner presented to the emergency room with facial numbness and burning unilaterally in the occiput/temple. Petitioner was prescribed Trileptal to help with the burning pain. On 11/8/08 petitioner had recurring symptoms of neuralgia.

Petitioner's husband, Christopher Hartnell, was called as a witness on behalf of petitioner. He testified that for her job at State Farm in the office she needed 11-13 licenses to sell insurance. On or about 2008 petitioner bid up to an underwriter assistant position. She was in that position for 1-1/2 years, and her husband testified this job was a bit of a struggle for her. Mr. Hartnell testified that before the accident she would go to dinner with friends, and had people over. She also drove without difficulty. At home she helped with the checkbook, did laundry, shopped, cleaned and kept the house clean. He observed no memory or focus issues, despite the fact that petitioner had reported these type of problems prior to the injury.

After the injury, he stated that she only worked for State farm for a few days. Mr. Hartnell testified that petitioner recently got SSDI. He testified that if a weather front comes in she cannot deal with people and shuts herself in. He stated that she also gets migraine headaches. Mr. Hartness testified that petitioner does not go out much. He stated that her memory is spotty, and she get distracted easily. He also testified that she is more emotional now. He stated that she only has 7-8 good days a month. Petitioner does a fairly good job with the checkbook. Mr. Hartnell testified that petitioner stopped seeing Dr. Moody due to financial reasons.

Mr. Hartnell testified that petitioner tried to volunteer at Advocate Bromenn and the McLean library, but could not always show up when scheduled. He testified that petitioner has searched for jobs, but found none. He testified that petitioner cannot multitask very well.

On cross-examination he admitted that petitioner had a history of headaches/migraines, and jaw injury prior to the work injury. In August of 2011 petitioner drove with her husband and grandkids to Florida for a vacation. They travelled on the highway with trucks.

Petitioner testified that she had problems with the noise and crowds when she volunteered at Advocate Bromenn. However, her facebook page shows her in a bar drinking with her friends. Petitioner testified that since 2/16/09 she has not worked in any paying job.

Today, petitioner testified that she experiences a lot of confusion and can't stay focused. She complained of headaches, anxiety and depression every day. She testified that she has 1-2 good days a week, but it varies depending on the weather. She testified that the bariatric pressure affects her, and she gets debilitating migraines. She testified that she can drive up to 15 miles, but concentration is an issue. The arbitrator notes that petitioner's trip to see Bose was further than 15 miles and she drover herself there. She testified that since

September of 2010 her headaches have improved, and they are not so severe all the time. She testified that she has breakthrough of memory. Petitioner also testified that she applied for jobs but never got none.

Petitioner testified that in September of 2013 she was in the car with her grandson, with someone else driving, and got into a motor vehicle accident. She testified that they were hit on the left side, and spun and hit a tree. She did not treat for these injuries. Petitioner testified that she was not in Mexico in October of 2009. Her passport shows her and her husband were there in March of 2009, one month after the work injury.

Hillary Sand, a friend of petitioner's for 25 years was called as a witness. She testified that before the accident petitioner was happy, fun loving, energetic, a party planner, went camping, was always ready to jump in, was busy with the kids, and worked 2 jobs. In 2015 Sand saw petitioner 6 times, because they do not live as close as they used to since petitioner moved to Atlanta. She testified that noise and commotion affect her. She stated that petitioner gets scattered, can't function, and is low key. Sand does not find petitioner full of life today.

Paula Degaramo Short, a friend of petitioner's for 28 years, was called as a witness on behalf of petitioner. She testified that in 2008 she saw petitioner every or every other weekend, and they did everything together. Currently, she sees petitioner about 5-6 times a year. She testified that petitioner is not as involved in doing things as she used to be. She testified that petitioner's memory does not seem the same, and she does not have memory of what they did they together. She testified that weather changes are almost crippling to petitioner.

Amanda Gibson, petitioner's daughter, was called as a witness on behalf of petitioner. She testified that she saw her mom every day before the accident, and close to every day now. She testified that before the accident she was always on the go and on the ball. She never sat down, ran everywhere, and was happy. She had great friends and did a lot with them. She testified that currently her mother does not work and stays home. She stated that she is not as kept as she used to be, and that her mom has difficulty getting tasks done. She testified that her mom is not involved in as many social things as before. She gave a specific situation where her mother forgot to buckle her daughter in the stroller and she fell out, but was not seriously injured. She testified that her mother watches her 4 year daughter after school, since that is where the bus drops her off. Sometimes, when she is not up to it, Gibson will pick up Amanda at the bus.

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

This claim was previously tried pursuant to Section 19(b) of Act on 9/10/10. One of the issues in dispute was causal connection. With respect to this issue, Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression, and anxiety, as well as her post concussion syndrome are all

directly related to her February 13, 2009 work related injury. Respondent did not appeal Arbitrator White's decision. Petitioner is not claiming any new injuries or conditions as a result of her work injury. As such, this arbitrator finds the conditions Arbitrator White found causally related to the work injury, are still causally related to the work injury. However, the arbitrator will address whether or not the treatment petitioner has received for these conditions since the 19(b) hearing on 9/10/10 was reasonable and necessary, and the impact these conditions now have as they relate to the nature and extent of petitioner's injury.

J. WERE THE MEDICAL SERVICES THAT WERE PROVDED TO PETITIONER REASONABLE AD NECESSARY? HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES?

Per the Request for Hearing, the medical bills petitioner is alleging were reasonable and necessary were offered as PX10. Petitioner offered into evidence 4 bills from Bloomington Radiology. The first one is for a CT of the head and chest x-ray performed on 10/26/09, in the amount of $215.00. Since these diagnostic tests were performed nearly one year before the first 19(b) hearing and sent to collections prior to the 19(b) hearing, the arbitrator has no credible evidence to support a finding as to who ordered these tests and the purpose of these tests, especially given the fact that prior to the injury on 2/13/09 petitioner had multiple tests ordered and performed for her preexisting migraines and facial numbness. The proper time to offer these bills was at the hearing on 9/10/10 with the proper supporting medical evidence. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these diagnostic tests were reasonable and necessary to cure or relieve her from the injuries she sustained on 2/13/09.

The second bill from Bloomington Radiology is for a duplex scan extreme vein LM performed on 10/26/09, in the amount of $97.00. Again, the arbitrator finds that since this diagnostic test was performed nearly one year before the first 19(b) hearing and sent to collections prior to the 19(b) hearing, the arbitrator has no credible medical evidence to support a finding as to who ordered this test and the purpose of this test, especially given the fact that there is no credible medical evidence in the credible record to support this type of diagnostic test. The proper time to present this bill was at the hearing on 9/10/10 with the proper supporting medical evidence. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve her from the injuries she sustained on 2/13/09.

The third bill from Bloomington Radiology is for 2 chest views in the amount of $46.00. These x-rays were performed on 2/15/11. Petitioner offered no credible medical evidence to support a finding that these x-rays were reasonable or necessary for her causally related conditions. Additionally, petitioner failed to offer into evidence any order by any treating doctor for these x-rays. As such, the arbitrator finds the petitioner has failed

to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

The fourth and final bill from Bloomington Radiology is for another chest x-ray on 9/3/11, in the amount of $38.00. Again, the arbitrator finds the petitioner offered no credible medical evidence to support a finding that this x-ray was reasonable or necessary for her causally related conditions. Additionally, petitioner failed to offer into evidence any order by any treating doctor for this x-rays. As such, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a report from Financial Recovery Services for services on 9/3/11 at Bloomington Medical Lab Phys in the amount of $137.00; services at Bloomington Medical Lab Phys on 2/15/11 in the amount of $62.40; services at OSF St. Joseph Medical Center on 2/15/11 in the amount of $871.31; services at OSF St. Joseph Medical Center on 2/24/11 in the amount of $214.05; and services at OSF St. Joseph Medical Center on 1/10/12 in the amount of $1,119.55. Given that the petitioner offered no credible medical evidence that identifies what these charges are for, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that this diagnostic test was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF Medical Group in the amount of $106.00 for services on 10/20/09 related to a contusion of her upper arm. Given that petitioner's injury was 2/13/09, and her 19(b) hearing was on 9/10/10, the proper time to present these bills for payment would have been at the hearing on 9/10/10. Additionally, the arbitrator finds no credible medical evidence to support the reasonableness and necessity of this service as it relates to her injury on 2/13/09. The credible medical records offered into evidence include no records from Sam Moore. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Next, petitioner offers into evidence a bill from Carey Harris for an office visit on 2/17/11 in the amount of $115.00; a bill from Caisus2 for an ultrasound of the abdomen on 2/24/11 in the amount of $133.00; a bill from Carey Harris for an office visit on 2/28/11 in the amount of $115.00; and a bill from Pamela Harris for an office visit on 10/6/13 in the amount of $222.00. The arbitrator finds the petitioner has offered no credible medical evidence to support a finding that these services were reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09. Additionally, the arbitrator notes that the balance due on all these bills is $0. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of

the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner then offered into evidence bills with service dates of 5/4/09 for a PT evaluation and service dates of 5/4/09, 6/9/09, 7/8/09, 7/15/09, 8/13/09 for neuromuscular re-education, and service date of 9/10/09 for therapeutic exercise. The service provider is not identified for any medical service on the bill offered into evidence. Given that these services were incurred before the 19(b) hearing on 9/10/10, and petitioner offered no credible medical evidence related to these bills to show that these services were reasonable and necessary and related to the accident on 2/13/09, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

The petitioner also offered into evidence a printout of charges from 02/18/09 through 09/17/09 for various exams, blood tests, and other medical services not fully described, or associated with any specific healthcare provider. Additionally, the reason for these services is not documented. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner then offered into evidence another printout of charges from Carle Clinic from 2/25/09 through 3/22/11 for various services that are not fully described, or associated with any specific healthcare provider. Additionally, the reason for all of these services is not documented. For these reasons the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill for services rendered by Dr. Warren from 4/1/10 to 5/15/14 in the amount of $3,310.00. Given that petitioner was referred to Dr. Warren by respondent's insurance carrier's nurse, in response to Arbitrator White's order that petitioner undergo the psychotherapy and psychiatry recommended by Dr. Catt, the arbitrator finds respondent shall pay, pursuant to Section 8(a) and Section 8.2 of the Act, the $3,310.00 for the services rendered by Dr. Warren.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for emergency room services on 9/3/11 in the amount of $2,210.30. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for an ultrasound of petitioner's abdomen on 2/24/11 in the amount of $415.00. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence a bill from OSF St. Joseph Medical Center for medical services on 2/15/11 in the amount of $1,688.20. Given that petitioner offered no medical records regarding the services rendered this day, the arbitrator finds the petitioner has failed to prove by a preponderance of the credible evidence that these medical services were reasonable or necessary to cure or relieve petitioner from the effects of her injury on 2/13/09.

Petitioner offered into evidence the bill of Dr. Moody from Central IL Phys. Assc. for services rendered on 11/8/11, 1/11/12, 1/25/12, 3/5/12, 4/4/12, 5/15/12 and 6/27/12, in the amount of $950, of which petitioner paid $835.00 directly to Dr. Moody. Given the fact that the arbitrator finds the treatment rendered by Dr. Moody was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 2/13/09, given that this treatment was ordered by Arbitrator White, the arbitrator finds the respondent shall reimburse petitioner for her $835 in out of pocket expenses, and pay the remaining $115 pursuant to Sections 8(a) and 8.2 of the Act.

K. WHAT TEMPORARY BENEFITS ARE IN DISPUTE?

Petitioner is claiming that she is entitled to temporary total disability benefits from 9/11/10 through 1/27/16. Respondent paid petitioner temporary total disability benefits from 9/11/10 through 6/17/11 in the amount of $19,305.20. Respondent is claiming that they are entitled to reimbursement of these temporary total disability benefits paid.

As a result of the 19(b) hearing on 9/10/10 Arbitrator White found that petitioner's cognitive difficulties, memory impairment, daily headaches, depression and anxiety, as well as her post concussion syndrome were all directly related to her February 13, 2009 work related injury, and that petitioner was temporarily totally disabled from 2/14/09 through 9/10/10 as provided in Section 8(b) of the Act. In response to Dr. Cattt's recommendation that petitioner undergo psychotherapy and psychiatric treatment petitioner presented to Dr. Pamela Warren. Dr. Warren then referred petitioner for medicine management. Petitioner sought treatment from Dr. Moody.

Following the hearing on 9/10/10, petitioner offered into evidence medical records beginning on 4/5/11. On 4/5/11 petitioner presented to Dr. Warren, a therapist respondent's insurance company nurse sent petitioner

to in response to Arbitrator White's order that petitioner be referred for psychotherapy and psychiatry that Dr. Catt's recommended.

Following her interview of petitioner; medical, educational, and social history; and mental status evaluation, Dr. Warren was of the opinion that petitioner was most likely going to need some additional psychological testing due to her concerns that petitioner showed clear evidence of symptom magnification, and in some cases some malingering with Dr. Alper. After 145 minutes of psychological testing, Dr. Warren opined that the results showed that in multiple scales petitioner was likely greatly exaggerating any cognitive concerns that she had. Dr. Warren found frank evidence of malingering. Dr. Warren assessed underlying depression related to anxiety and depression, and not related to any type of brain injury or any sustained effects from the fall on 2/13/09. On 6/7/11 Dr. Warren recommended medication and cognitive-behavioral psychotherapy, and a referral to a psychiatrist for bio-feedback therapy.

Following this treatment by Dr. Warren, respondent terminated petitioner's temporary total disability benefits. The arbitrator finds this termination of benefits not supported by the findings of Arbitrator White and the recommendations of Dr. Catt.

From 6/30/11 through 11/3/11 petitioner underwent counseling and psychotherapy with Wilma McLaughlin at Agape Counseling. McLaughlin recommended that petitioner consult with a psychiatrist for medication evaluation and apply for services from the Department of Rehabilitation Services of the Illinois Department of Human Services. The arbitrator finds these services consistent with the recommendation of Dr. Catt, as ordered by Arbitrator White. McLaughlin did not return petitioner to work.

On 11/8/11 petitioner next presented to Dr. Moody at Central Illinois Psychiatric Association for medicine management and therapy. Petitioner saw Dr. Moody seven times through 6/26/12. Following her testing and examination, as well as review of prior medical records, Dr. Moody noted that petitioner, despite her denial of any past psychiatric history, had been on Cymbalta, and perhaps Celexa and Ambien. She also noted that petitioner had been seen by a neurologist before the work injury for TMJ and migraine headaches. Petitioner reported that her headaches and dizziness had improved somewhat. Dr. Moody diagnosed petitioner as suffering a significant degree of anxiety; displayed some difficulties with hyper-sensitivity of hearing, tactile and visual; post-concussion syndrome; and difficulties with memory and judgment. She was also of the opinion that prior psychological testing indicated that some of petitioner's dysfunction might be due to anxiety and depression, and not completely due to her underlying brain damage. She opined that petitioner was capable of handling most, if not all in-house ADL's, has some limited function in the community due to her restrictions on

driving and getting lost sometimes when she leaves home. Based on these opinions the arbitrator does not find petitioner had yet reached maximum medical improvement or was able to return to her regular duty job.

On 12/13/12 petitioner underwent a Section 12 examination performed by Dr. Rothke, at the request of her attorney. Dr. Rothke performed extensive psychological testing, performed a record review, and interviewed petitioner and her husband. Overall, he opined that petitioner may have some over-reporting of cognitive and somatic difficulties. His diagnoses were major depressive disorder, and moderate and generalized anxiety disorder related to her fall at work. Dr. Rothke further opined that petitioner's depression or anxiety are not directly related to brain changes. He noted that petitioner had no trouble performing the computer part of the testing.

On 10/14/13 petitioner underwent a Section 12 examination performed by Dr. Obolsky, at the request of the respondent. Dr. Obolsky performed a forensic evaluation and psychiatric evaluation which was comprised of a record review, forensic psychiatric interview, forensic psychological and cognitive testing, and data analysis. Based on this evidence and his reasoning, Dr. Obolsky opined that petitioner was malingering her cognitive and emotional symptoms and had reached MMI in May of 2009. He opined that petitioner is mentally fit for full time employment. He opined that no mental treatment was required. He opined that at worst, petitioner experienced a mild traumatic brain injury, and her expected course of recovery to her preexisting level of functioning would have been 3 months. Dr. Obolsky reviewed petitioner's Facebook posts. He also noted that Dr. Bhosale in November of 2009 was of the opinion that petitioner and her husband were grappling with having difficulty accepting the fact that her symptoms are not related to any structural or physiological injury to the brain. He opined that her Facebook posts that show her having drinks in a bar on 12/7/09 contradict a diagnosis of depression and anxiety. He also found it significant that Dr. Frank opined that his examination of petitioner was "entirely within normal limits" and "she has a lot of subjective complaints" and appeared to have some somatoform type of disorder in 2004. He also relied on Dr. Frank's opinion that petitioner could function in her previous capacity with computers and telephone at State Farm.

On 4/15/15 petitioner underwent a Vocational Assessment performed by Dennis Gustafson, at the request of her attorney. The only medical records of petitioner that Gustafson relied on were the findings and opinions of Dr. Rothke. He also relied on an interview with petitioner and her husband, a labor market survey performed by Coventry Worker's Compensation, and petitioner's SSDI award letter. Based on this, Gustafson concluded that petitioner was unable to meet the productivity requirements and overall employment expectation of any employer in any job as normally performed within the economy. He also believed she would not be a candidate for vocational educational/training. The arbitrator finds it significant that Gustafson did not review any other

medical records other than those of Dr. Rothke. For this reason the arbitrator gives little weight to Gustafson's opinions.

Lastly, petitioner underwent a Vocational Rehabilitation Evaluation by Bose on 6/24/15. Bose, unlike Gustafson, reviewed numerous documents including those of Gustafson, Dr. Rothke, Dr. Moody, Dr. Obolsky, Dr. Warren, Dr. Alper, and petitioner's Facebook entries. She also collected behavioral and biographical date from petitioner, vocational history, and current vocational rehabilitation status. She found it significant that Dr. Alper, Dr. Warren and Dr. Obolsky all questioned whether petitioner's symptoms were exaggerated, and whether the tests represented an accurate measure of her abilities. In conclusion, Bose found no medical or physiological opinions to support a finding that petitioner was permanently and totally disabled from work. Although she did note that petitioner did have neuropsychological testing that only reflected minimal deficits which should be factored into her vocational plan. Based on petitioner's self reported activities of daily living, results of her neuropsychological testing, and petitioner's presentation on social media that was inconsistent with her claims that she could not drive on the highway with trucks around her, and that she could not be in crowds, or where it was loud. Petitioner herself stated that she drove to Florida with her husband on the highway where there were trucks. Also petitioner posted pictures of her in a bar drinking and having a good time with a group of people. She also had a lot of people over to her house for the July 4th weekend and they all camped out, and hung out in her yard/house.

The reason petitioner gave Bose for not looking for work was that she did not think she would be able to be productive or reliable primarily due to her headaches, which the arbitrator notes were preexisting as far back as at least 2004 when she received extensive treatment for her migraines and facial numbness, that included an MRI of the brain, a spinal fluid test, and visits to a neurologist. At that time, petitioner also complained of left jaw pain, and neck and shoulder pain radiating from the base of her skull for the past 8 years. Petitioner also underwent injections that provided no relief of her headaches. These symptoms continued up until the time of her injury on 2/13/09.

Based on the above, as well as the credible evidence, the arbitrator finds that petitioner was no longer temporarily totally disabled, and had reached MMI, when she underwent her Vocational Assessment by Bose. Bose had outline various positions that petitioner was capable of performing. Given the fact that each and every medical doctor was of the opinion that petitioner was capable of performing some type of work, and Bose outlined what these positions might be, the arbitrator finds the only obstacle to petitioner partaking in a vocational program at that point was her own belief that she was unable to be productive or reliable due to her headaches. Given that a fact that petitioner had severe headaches for years prior to the work injury, and a

number of medical doctors diagnosed petitioner with some level of malingering, the arbitrator finds the petitioner had an obligation to at least try vocational rehabilitation at that time. Given the fact that she did not, the arbitrator finds the petitioner was no longer temporarily totally disabled after 6/24/15, based on the opinions of Bose that petitioner was a candidate for vocational rehabilitation. At no time prior to this date did the respondent offer vocational rehabilitation for petitioner. The arbitrator finds that despite the opinion of a lot of petitioner's treating and examining doctors that petitioner is a malinger, most of them believed petitioner's current condition of ill-being following her injury may prevent her from returning to her regular duty job, but did not prevent her from returning to some type of work.

The arbitrator finds the petitioner was temporarily totally disabled from 9/11/10 through 6/24/15, a period of 249-4/7. As such, the arbitrator finds the respondent shall pay petitioner temporary total disability benefits of $482.63/week for 249-4/7 weeks. Respondent is also entitled to a credit of $19,305.20 for temporary total disability benefits paid after 9/10/10.

L. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Although petitioner reported to various healthcare providers that she had no problems with her head prior to the injury on 2/13/09, the arbitrator finds there is at least an 5 year history of headaches and facial numbness that petitioner had prior to the injury on 2/13/09. This is documented in her medical records prior to 2/13/09 that show petitioner treated for numbness to the right side of her face and head. Petitioner complained of a history of migraines and facial numbness. For these conditions she underwent an MRI of the brain, a referral to a neurosurgeon, a spinal fluid test, and complained of left jaw pain, and neck and shoulder pain for the past 8 years. She also reported that she underwent some injections to relieve her pain, but they did not work.

Of all the medical doctors petitioner treated with, many found signs of malingering. These doctors included Dr. Alper, Dr. Rothke, Dr. Frank, Dr. Moody, Dr. Warren and Dr. Oblosky. Additionally, there is not one doctor that felt petitioner could not return to some kind of work. The only one who believed petitioner could not return to any type of work was Gustafson, who was hired by petitioner's attorney, and only reviewed the medical records of one doctor, Dr. Rothke, who even opined that petitioner was not permanently totally disabled. In fact, petitioner had no problems performing the computer part of Dr. Rothke's testing, and no problem accessing and posting on social media, and performing a very limited online search for jobs.

The arbitrator also questions some of petitioner's claims of needing to be away from crowds and loud noises given her facebook posts that showed her in Mexico with her husband having a good time, and in a bar drinking with her friends. The petitioner also went to a hockey game. The petitioner also claimed she could not drive on the highway near trucks, but drove all the way to Florida and back with her husband. She also drove

herself from Atlanta, IL to Steger, IL for her appointment with Bose, which was more than the 15 miles she claimed she could drive. She also had a group of people come and spend the 4th of July weekend with her and her family camping in her yard and spending time together. The arbitrator finds petitioner's, her husband's, and her friends testimony regarding what she can and cannot do often inconsistent with what she actually did.

Based on the credible medical record, the arbitrator finds the petitioner sustained minimal deficits which should be factored into her vocational plan. However, since petitioner refused any vocational plan due to her beliefs that she was unable to be productive or reliable primarily due to her headaches, absent any such opinion from a medical doctor, the arbitrator finds the petitioner sustained a 30% loss of use of her person as a whole pursuant to Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF GRUNDY)

☐ 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 Down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Tim Kern,

Petitioner,

vs.

NO: 09 WC 19600

17IWCC0483

Sandwich Comm. Fire Protection Dist,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Respondent herein and notice provided to all parties, the Commission, after considering the issues of accident, causal relationship, temporary total disability benefits, nature and extent, and evidentiary rulings and being advised of the facts and the 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.

Evidentiary Rulings

At the onset, the Commission notes there appears to be some confusion as to objections raised based upon foundation versus hearsay as well as the certification provision found in Section 16 of the Act. "The rules of evidence apply to all proceedings before the Commission or an arbitrator, expect to the extent they conflict with the Act. [citations omitted]." *Greaney v. The Industrial Commission*, 358 Ill. App. 3d 1002, 1010 (2005). Illinois Rule of Evidence 901 requires authentication and identification of a document. *Ill. R. Evid. 901* (2017). "Absent proper authentication and identification, the document cannot be admitted into evidence. [citation omitted]." *Id.* at 1011. Section 16 of the Act does not convert an objectionable hearsay document into an admissible document because the foundational requirements have been met.

Foundation and hearsay are separate grounds for objection. See *National Wrecking Company v. The Industrial Commission*, 352 Ill. App. 3d 561 (2004).

But even before the foundation requirements are addressed, the document must be admissible pursuant to an exception of the hearsay rule. Illinois Rules of Evidence 803(4) allows such exception for statements made for purposes for medical diagnosis or treatment, and 803(6) allows such exception for business records. *Ill. R. Evid. 803* (2017). It is presumed such records are accurate and trustworthy. See *Caponi v. Larry's 66*, 236 Ill. App. 3d 660 (1992) and *People v. Alsup*, 373 Ill. App. 3d 745 (2007). The exception though does not apply to reports or records prepared in anticipation of litigation.

Respondent objected on the grounds of hearsay to the June 3, 2008 report prepared by Dr. Eric Janota and the August 27, 2008 report prepared by Dr. John Gocke. PX2. The Arbitrator sustained Respondent's objection as to the June 3, 2008 report but admitted the August 27, 2008 report. Respondent also objected to the letter dated July 7, 2008 prepared by William King (PX8) on the grounds of both hearsay and foundation. The Arbitrator admitted the July 7, 2008 letter.

The Commission finds Respondent's objections should have been sustained and all three documents excluded. Relative to the reports prepared by Dr. Janota and Dr. Gocke, such reports were prepared at the behest of Petitioner and not for the purpose of diagnosis or treatment or in the regular course of treatment. Certainly "under certain circumstances the probability of accuracy and trustworthiness may serve as a substitute for cross-examination under oath. [citation omitted]." *United Electric Coal Company v. The Industrial Commission*, 93 Ill. 2d 415, 420 (1982). Those circumstances are not present here. Both letters were prepared months after the fact of injury and at the request of Petitioner. Additionally unlike in *United Electric Coal Company*, Respondent's examining physician did not rely on the reports to form the basis of his opinion. RX1, p.8.

Relative to the letter dated July 7, 2008, even assuming *arguendo* it falls into a recognized hearsay objection, an adequate foundation must be laid for it to be accepted into evidence. "In order to lay an adequate foundation, the proponent must present evidence to demonstrate that the document is what it claims to be. [citation omitted]." *Greaney v. The Industrial Commission*, 358 Ill. App. 3d 1002, 1011 (2005). No such foundation was laid. Mr. William King was not present at the hearing, and Petitioner could not remember the circumstances surrounding Mr. King's authoring of such letter. T. 35.

The Commission finds all three documents to be excluded from evidence. As such the Commission strikes any references or findings made by the Arbitrator in his decision as it relates to the excluded documents.

17IWCC0483

Causation

Even without such evidence, the Commission finds Petitioner proved a causal relationship between his undisputed accident and his subsequent condition of ill-being - deep vein thrombosis. In so finding, the Commission affords greater weight to the opinion of Dr. Coe over the opinion of Dr. DeBord and affirms and adopts the finding of the Arbitrator in that regard except to the extent as outlined above regarding the excluded documents.

Temporary Total Disability Benefits

The Commission finds Petitioner failed to prove entitlement to temporary total disability benefits and vacates the Arbitrator's award of such benefits. "To show entitlement to TTD benefits, claimant must prove not only that he did not work, but that he was unable to work. [citation omitted]." *City of Granite City v. The Industrial Commission*, 279 Ill. App. 3d 1087, 1090, 666 N.E.2d 827 (1996). Petitioner testified he did not work for the two weeks following the accident of September 8, 2007 (T. 25) as well as from December 1, 2007 to March 1, 2008. T. 31. Petitioner testified he sought no medical treatment as related to the accident until December 1, 2007. T. 27. The medical records offered into evidence concerning Petitioner's treatment from December 1, 2007 through March 1, 2008 fail to evidence any medical provider finding Petitioner unable to work. PX1 & PX3. Accordingly, the Commission vacates the award of temporary total disability for the period of December 1, 2007 through March 1, 2008 representing 12 6/7 weeks.

Nature and Extent

The Commission notes the Arbitrator's findings as to Petitioner's complaints and the findings of Dr. Coe and Dr. DeBord. The Commission weighs the evidence accordingly and reduces the permanency finding to 7.5% loss of use of the left leg pursuant to Section 8(e) of the Act.

The Commission affirms all else.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Arbitrator's June 29, 2016 decision is modified for the reasons stated herein and otherwise affirmed and adopted.

IT IS FURTHERED ORDERED BY THE COMMISSION that the Respondent pay the medical bills contained in Petitioner's Exhibits 6 and 7 pursuant to Section 8(a) and Section 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.00 per week for a period of 16.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the permanent disability of the left leg to the extent of 7.5%.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,800.00. 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.

AUG 2 - 2017

DATED:
LEC/maw
o06/06/17
43

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KERN, TIM
Employee/Petitioner

Case# **09WC019600**

17IWCC0483

SANDWICH COMM FIRE PROTECTION DIST
Employer/Respondent

On 6/29/2016, 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 0.34% 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:

1869 PRESBREY & ASSOCIATES
KURT A NIERMANN
821 W GALENA BLVD
AURORA, IL 60506

0507 RUSIN & MACIOROWSKI LTD
TIM CROWLEY
10 S RIVERSIDE PLZ SUITE 1925
CHICAGO, IL 60606

17IWCC0483

STATE OF ILLINOIS)
)SS.
COUNTY OF GRUNDY)

☐ 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

TIM KERN
Employee/Petitioner

v.

SANDWICH COMM. FIRE PROTECTION DIST
Employer/Respondent

Case # **09** WC **19600**

Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **Ottawa**, on **5/25/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **9/8/07**, 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*** 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 **$52,000**; the average weekly wage was **$1,000.00**.

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

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

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

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

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

ORDER

Respondent shall pay the reasonable and necessary medical services as outlined in the attached decision, as provided in Sections 8(a) and 8.2 of the Act

Respondent shall pay Petitioner temporary total disability benefits of $666.66/week for 12 6/7 weeks, commencing 12/1/07 through 3/1/08, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from 9/8/07 through 5/25/16, and shall pay the remainder of the award, if any, in weekly payments.

Respondent shall pay Petitioner permanent partial disability benefits of $600.00/week for 21.5 weeks, because the injuries sustained caused a 10% loss of the left leg, as provided in Section 8(e) of the Act.

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

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

Robert E Abrams

Signature of Arbitrator

June 6, 2016

Date

JUN 29 2016

17IWCC0483

MEMORANDUM OF DECISION OF ARBITRATOR

Petitioner Petitioner worked as a volunteer firefighter for respondent. Petitioner was working in that capacity on 9/8/07 at the local tractor pull. The front end of a participating "mighty midget" tractor started bouncing up and down and the front tire broke off, flying toward two mothers and their children and the section where the handicapped attendees were located. When the kids did not respond to Petitioner's yells of "tire, tire, tire", Petitioner exited respondent's emergency vehicle, put the children behind him and stood in front of the bouncing tire. The tire struck Petitioner's left leg above the knee, knocking him to the ground and possibly knocking him out. In any event, the attending emergency medical personnel checked him out. However, Petitioner denied further treatment when he realized that he had not broken any bones. Petitioner was able to walk at the scene but with a marked limp. (PX1 Dep.Ex.2) Petitioner's leg turned black and blue from the location where the tire hit the leg down into his left calf. (PX1 Dep.Ex.2) Petitioner noted that the leg also stiffened up and swelled and that he could not walk for two weeks after the accident. Petitioner explained that he did not seek treatment during this time as he simply thought it was just a bad bruise down his leg which would go away. He did carry out home therapies for the leg including icing and heat application, noting that the bruising slowly faded and the swelling decreased over the following weeks. (PX1 Dep.Ex.2)

Petitioner returned to work in his construction business two weeks after the accident. About two months after the accident, he again noticed left foot, ankle and calf swelling, without any pain. (PX1 Dep.Ex.2) Petitioner consulted with paramedics at the Sandwich Community Fire Protection District who recommended formal treatment. He obtained a Doppler ultrasound prescription from Dr. Sutkus and went to Valley West Community Hospital for the study on 12/1/07. (PX3) The scan was interpreted as showing deep vein thrombosis in the left popliteal and anterior tibial veins.

Dr. Sutkus read the scan on 12/1/07 and admitted Petitioner to Valley West Community Hospital for further evaluation and anticoagulation therapy. Anticoagulation was started with Lovenox and Coumadin for left leg deep vein thrombosis.

Petitioner followed up with his primary care physician, Dr. Eric Janota, on 12/3/07. Dr. Janota found left calf swelling and some swelling of the left ankle. Dr. Janota recommended continuing anticoagulation therapy with clotting monitoring and use of a left leg support hose. Petitioner continued following up with Dr. Janota through April of 2008 for coagulation monitoring.

17IWCC0483

On 5/12/08, Petitioner underwent a repeat venous scan of the left leg at Rush Copley Medical Center which was interpreted as showing deep vein thrombosis of the left superficial femoral vein extending to the popliteal vein with areas of partial recanalization of the popliteal vein.

On 5/19/08, Petitioner was seen by a vascular specialist, Dr. Gocke, at LaGrange Memorial Hospital. Dr. Gocke noted his left leg swelling and history of DVT following the tire injury in 2007. Dr. Gocke diagnosed the condition as partial recanalization of a venous thrombosis in the left femoral vein and popliteal vein with evidence of left popliteal vein scarring. He did not believe that the DVT was acute at that point. Dr. Gocke recommended additional anticoagulation therapy. This treatment was carried out under the care of Dr. Janota. (PX4)

On 8/27/08, Dr. Gocke addressed an office note to Dr. Janota, explaining that the left leg injury from September of 2007 caused a large left thigh and calf hematoma which represented a "major precipitating risk factor for new deep vein thrombosis". (PX2) Dr. Gocke also noted that Petitioner had no evidence of a hypercoagulability disorder, leading Gocke to conclude that Petitioner's left leg DVT was most likely due to trauma and was not idiopathic. (PX2)

Respondent's counsel questioned Petitioner over why this note was created by Dr. Gocke. Petitioner explained that Dr. Gocke asked him whether his leg had sustained major impact. Petitioner told him about the accident involving the tire and Gocke responded that he could still see the imprint of the tread in Petitioner's thigh.

Petitioner later underwent a repeat left leg venous duplex scan at LaGrange Memorial Hospital on 1/19/09, which showed venous scarring as had been seen in the May 2008 scan. The venous scarring was described as "likely compatible" with postphlebitic venous vascular incompetence. No evidence of acute DVT was found.

Petitioner continued in the care of Dr. Janota. Anticoagulation therapy was eventually stopped but Petitioner was advised to use a compression stocking on the leg. However, Petitioner was back on anticoagulant therapy by the time of the hearing.

Petitioner explained how his leg was different following the accident with the tire. Petitioner experienced pain in the leg with standing or sitting of more than 45 minutes. He also noted that his left leg would become more tired with use. He had none of these symptoms in the right leg.

He expressed similar complaints to Dr. Jeffrey Coe during his evaluation of 12/18/12. (PX1 Dep.Ex.2) Petitioner noted that he experienced recurrent leg swelling from the knee to the ankle. The swelling was caused by standing more than an hour at a time and that he experienced throbbing left leg soreness with the swelling. He also reported mild stiffness of the leg with "tightness".

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

Petitioner has proven that his condition of ill-being in the left leg is causally related to the 9/8/07 accident. Causation is shown by the timeline of events, the mechanism of accident, the causation opinion from the vascular specialist Dr. Gocke and the causation opinion from the occupational medicine specialist Dr. Jeffrey Coe.

Petitioner testified without rebuttal that he had had no problems with the left leg prior to the blow from the tire. He was 52 years of age and worked in a variety of construction activities. However, the tire impact caused immediate injury to the area of the leg where the thrombosing was later found, including the calf area where the popliteal vein travels as evidenced by the bruising and swelling that Petitioner testified to, again without rebuttal. He testified that he had difficulty walking for two weeks following the accident, although his swelling and bruising went down within a few weeks of the accident. However, he later experienced significant swelling in the leg with his normal construction activities.

Causation is further supported by the opinions of the informed medical specialists. Dr. Gocke related the DVT to the tire accident in his 8/27/08 letter to Dr. Janota. (PX2) Dr. Gocke noted that he had called and talked with Janota about Petitioner's case and that he had reviewed both Doppler scans and Petitioner's lab results. Dr. Gocke opined that Petitioner's DVT was due to the significant trauma he sustained when struck by the tractor tire. He felt that the "trauma which preceded his clot diagnosis by 2-3 months was indeed the major precipitating risk factor for developing the deep vein thrombosis which he sustained." Respondent itself elicited the testimony which explained the events which led to the note being sent from Grocke to Janota. Petitioner explained that Dr. Gocke told him the extensive clotting would have to be the result of a major impact to the leg and that Gocke still saw imprint of the tire tread in the thigh. In a 6/3/08 note, Dr. Janota had earlier reported that Petitioner's leg DVT was secondary to the accident involving the tire on 9/8/07. (PX2)

Dr. Jeffrey Coe, Petitioner's IME, agreed that the extensive clotting in the leg was due to the tire impact rather than Petitioner's subsequent work activities. Dr. Coe is a board certified specialist in occupational medicine. (PX1 p.3-4) Part of his area of training involves the determination of causes for injuries. (PX1 p.4) Petitioner's history of accident was that he was attending the Sandwich Fair as a firefighter when one of the tires broke off a tractor, flying through the air and striking him in the left thigh, knocking him to the ground. (PX1 p.6) Petitioner developed immediate pain in the thigh, started walking with a limp and developed a large bruise and swelling of his left thigh that extended into his left calf. (PX1 p.6) He treated the injury himself and the bruise gradually faded. (PX1 p.6) The swelling decreased over a few weeks. (PX1 p.6) And two months after the incident, he developed additional swelling in his left calf, ankle, foot and was diagnosed with deep venous thrombosis in his left leg. (PX1 p.6) As part of his analysis, Dr. Coe examined all the medical reports and records of the treating physicians from 2008 and 2009. (PX1 p.6) After reviewing the records and examining Petitioner, Dr. Coe opined to a reasonable degree of medical certainty that there was a causal relationship between the 9/8/07 accident involving the tractor tire and Petitioner's thrombosed

condition in the left leg. (PX1 p.7) Dr. Coe noted that the thrombosing was located in the left calf and below in several vessels, including the popliteal artery and tibial artery. (PX1 p.8) Inflammation of the blood vessels causes that type of injury. (PX1 p.8) And the history reported in the 12/1/07 emergency room record was unlikely to have been the source of the extensive thrombosing that was identified. (PX1 p.8) This record contained a history of Petitioner slipping off a stool, twisting his ankle and the ankle swelling up. (PX1 p.8) The postinjury thrombophlebitis post phlebitis vascular inflammation was more likely caused by a large tire striking the leg rather than simple twisting of the ankle. (PX1 p.8-9) Dr. Coe further noted that the vascular specialist who treated Petitioner also attributed the thrombosing to the tire incident. (PX1 p.9) Dr. Coe also noted that Petitioner had persisting postinjury venous vascular incompetence in the left leg. (PX1 p.10) This meant that he had sluggish blood return through his left leg due to vascular injury to the blood vessel and their associated valves. (PX1 p.10) With this condition, Petitioner remained at an increased risk for recurrent episodes of left leg deep vein thrombosis. (PX1 p.10) Dr. Coe opined that Petitioner could expect to experience left lower leg swelling at the knee and below, particularly with anything that increases the pressures within the left leg. (PX1 p.11) This would include prolonged standing, walking for long periods of time, prolonged sitting with his leg dependent, and his leg hanging down. (PX1 p.11) Dr. Coe noted that those sorts of things were what Petitioner reported that he experienced now. Petitioner reported having discomfort and swelling in his left lower leg if he stood for an hour or more. (PX1 p.11) He also experienced some aching or throbbing discomfort when his leg was swollen. (PX1 p.11) On cross examination, Dr. Coe noted that the initial emergency room records reported twisting the ankle with some swelling, followed with swelling into the calf the next day. (PX1 p.15) Dr. Coe also noted that according to Petitioner, the history contained in the ER note was not correct. He had not actually twisted his ankle or injure his foot in any way. (PX1 p.16) Dr. Coe further noted that ankle twisting can cause pain and swelling and difficulty in movement. (PX1 p.19) But in an otherwise healthy individual, it would be an uncommon cause of deep vein thrombosis. (PX1 p.19)

In addition to the medical opinions, there is extant in the record a written 7/7/08 statement by respondent's Fire Chief that the tire accident occurred and that Petitioner was treating for clotting in his leg from the trauma of the impact of the tractor tire to the leg.

Respondent challenged causation on the basis of a record review performed by Dr. James DeBord as well as the presenting history contained in the 12/1/07 visit to Valley West Community Hospital and the interval of time which passed between the date of injury and the first manifestation in the medical records that Petitioner had developed the condition that is the subject of this hearing.

Respondent hired James DeBord MD to peform a record review for the case. Dr. DeBord is a vascular surgeon in practice since 1979 affiliated with the Department of Surgery at the University of Illinois College of Medicine. (RX1 p.6) Dr. DeBord opined that Petitioner's DVT resulted from the 11/28/07 ankle twisting incident rather than the tire accident, for which

Petitioner never sought treatment. (RX1 p.10) Dr. DeBord also noted that Petitioner was now at greater risk for recurrence of DVT as his condition is a known risk factor for repeat DVT. (RX1 p.12) Dr. DeBord recommended use of a course of prophylactic means whenever he is at increased risk for DVT, such as before elective surgery. (RX1 p.12) He noted that Petitioner also had signs and symptoms of chronic venous insufficiency which may become chronic issue with leg swelling and venous valvular insufficiency that may, over a long period of time, result in changes to the lower leg including ulceration if not properly and continuously managed with medical measures.

On cross-examination, Dr. DeBord was asked about the assumptions he was using for his causation analysis. He had not spoken with Petitioner so he had no details of the accident involving the tire. (RX1 p.15) This limitation was critical to the merit of his causation analysis, because he settled on the assumption that Petitioner had no symptoms after the tire accident to which he could attribute to a vascular injury. (RX1 p.16) Without any significant complaints following the blow from the tire, he could not draw a connection between the DVT and the tire impact. As outlined above, his assumption is at odds with the facts of the case. The Petitioner testified without contradiction that the tire impacted a large portion of the leg, resulting in pain, limping, significant swelling and bruising throughout the leg. While Petitioner initially treated the condition on his own, it took weeks for the swelling to reduce and the bruising to improve. By comparison, the ankle event, whether he twisted the ankle or just stepped up and down repeatedly over the work day, resulted in discreet swelling in the ankle on the day of the visit to the ER. The calf swelling did not show up until the next day and there was never any evidence of bruising from the ankle event. Dr. DeBord's causation analysis was not based on the details of the accident or the sequalae of same. Further, Dr. DeBord had not seen the Doppler scans and had no idea whether the clotting found on the scans was echolucent or echogenic. (RX1 p.22) This is important as an echolucent appearance would be more consistent with a recent thrombosing event and an echogenic appearance would arise as the clot aged, per his own testimony. The physician who read the 12/1/07 scan did not describe it one way or the other (RX1 p.22) and Dr. DeBord recommended that the parties go back to the physician who read the scan to see whether it was echolucent or echogenic. (RX1 p.19) Dr. DeBord simply assumed that the clot appeared recent as the physicians treated it as if it was an acute thrombosis. (RX1 p.22) Without knowledge of what the clotting looked like during the Doppler scans, Dr. DeBord logically could not use the scans to date the injury or to rule out the 9/8/07 accident as the source for the clotting. There are no hard and fast rules as to how long it takes an echolucent clot to turn echogenic. (RX1 p.21-22) In his experience, the change in lucency would occur over a three to four month period. (RX1 p.18) However, the tire accident and 12/1/07 hospital visit were less than three months apart. So he could not logically rule out the tire impact as the source of the clotting. (RX1 P.20)

Given Dr. DeBord's lack of information about what symptoms Petitioner had from the 9/8/07 accident, his failure to review the Doppler scans, his lack of information about the characteristics of the clotting and his admission that we are dealing with a multi-month

transition period for the clot to evolve, there is a relatively slim basis for accepting Dr. DeBord's opinion on causation.

Wherefore, based on the record as a whole, the Arbitrator finds that Petitioner has proven a causal relationship between his 9/8/07 accident and his present condition of ill-being in the left leg.

Issue J- Has respondent paid all appropriate charges for all reasonable and necessary medical expenses?

Given the findings on causation, respondent is responsible for paying for treatment related to the injury. This includes the treatment from Drs. Janota (Sandwich Family Practice), Gocke, Rush Copley Medical Center, LaGrange Memorial Hospital and Valley West Community Hospital as well as the miscellaneous bills itemized as PX7. To the extent that bills were paid by group insurance, respondent will hold Petitioner harmless from reimbursement demands from the group carrier for such treatment and reimburse (through payment to Petitioner) the payments made by the group carrier. Respondent shall also reimburse Petitioner for his co-pays which are itemized as PX6.

Issue K- What temporary total disability benefits are owed?

Petitioner testified that he was not able to work for two weeks after the accident as he could not walk. He missed an additional three months from the 12/1/07 hospital visit to 3/1/07. Dr. Janota verified in his 6/3/08 note that Petitioner had missed the three months of work (December, January and February 2008) while treating for the DVT. (PX2) Respondent shall pay TTD for the missed time documented in the medical records, but not for the two weeks testified to by Petitioner immediately after the accident, as no medical records exist to verify same, for a total of 12- 6/7 weeks.

Issue L- What is the nature and extent of the injury?

Given the date of the accident, nature and extent are not governed by the amendments passed in 2011.

Petitioner now experiences occasional swelling in the left leg which he did not have for 52 years before the accident. He has permanent scarring in the popliteal vein, anterior tibial vein and superficial femoral vein. (RX1 p.24-25) He experiences pain and swelling in the leg with standing or sitting for more than 60 minutes.

Dr. DeBord admitted that Petitioner now has signs and symptoms of chronic venous insufficiency which may become chronic issue with leg swelling and venous valvular insufficiency that may, over a long period of time, result in changes to the lower leg including ulceration if not properly and continuously managed with medical measures. Dr. Coe felt that Petitioner would expect to experience left lower leg swelling at the knee and below, particularly with anything that increased pressures within the left leg. (PX1 p.11) This would include

prolonged standing, walking for long periods of time, prolonged sitting with his leg dependent, and his leg hanging down. (PX1 p.11) Under the circumstances and given the permanent nature of the condition as well as the statutes and awards governing losses from this date, Petitioner has proven a 10% loss of use to the 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 Accident	☐ Second Injury Fund (§8(e)18)
	☐ PTD/Fatal denied
☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

SCOTT MORAN,
Petitioner,

v.

NO: 10 WC 20287

17IWCC0484

VILLAGE OF HOMEWOOD,
Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the First District Appellate Court, Workers' Compensation Division. In its July 29, 2016 opinion, the Court held the Commission's decision finding Petitioner did not sustain a compensable mental-mental trauma was against the manifest weight of the evidence. The Appellate Court found Petitioner's "psychological injuries stemmed from a single, traumatic event on March 30, 2010, and he is entitled to recover for his psychological disability." *Moran v. Illinois Workers' Compensation Commission*, 2016 IL App (1st) 151366WC, ¶48. The Appellate Court reversed the judgment of the circuit court and remanded the matter to the Commission to address the remaining issues.

Findings of Fact

Hearings were held before Arbitrator Thompson-Smith on January 7, 2013 and September 30, 2013. The issues in dispute were accident, notice, causal connection, and nature and extent. ArbX1. Although medical was initially identified as a disputed issue on the Request for Hearing, the parties stipulated on the record the medical bills had been paid so that was no longer at issue. T.6-7. The parties further stipulated Petitioner was temporarily and totally disabled from April 8, 2010 through June 20, 2010, and during that period received full pay pursuant to the Public Employee Disability Act. ArbX1.

17IWCC0484

As the threshold issues of accident and causation have already been resolved in Petitioner's favor, the Commission will limit the recitation of facts to those necessary for resolution of the remaining disputed issues.

Petitioner Scott Moran worked as a firefighter/paramedic for Respondent Village of Homewood since February 22, 1991. T.54. In May of 2006, he was promoted to lieutenant. T.55. With this elevated rank, Petitioner's duties at emergency calls vary depending on the circumstances of the call: sometimes he is hands-on fire-fighting and sometimes he is in a supervisory role. T.56.

As detailed in the First District Appellate Court opinion, Petitioner was the Incident Commander at a house fire on March 30, 2010. T.59. As Incident Commander, Petitioner directed the firefighters where to go and what to do at the scene. Petitioner testified he observed two firefighters enter the house through the front door, so he ordered a line be taken into the house after them. T.60. This hose was manned by firefighters Brian Carey and Karra Kopas. During the fire suppression efforts, there was a flashover; this was described as an instantaneous increase in heat and burst of fire. T.22-23. Firefighter Carey suffered grave injuries during the flashover and passed away later that night.

Following Firefighter Carey's death, Respondent implemented its Emergency Operation Plan, meaning Homewood Fire Department personnel ceased performing fire suppression and emergency medical service operations; instead, firefighters from neighboring communities staffed the Homewood station and responded with their equipment and personnel. T.75, 167-168. The EOP was in effect for a week to 10 days. T.163-164.

Petitioner testified he went to the station on April 9, 2010 for a pension board election. T.78. Petitioner explained he decided to attend because he needed something to do as he "just couldn't sit at home anymore." T.78. While at the station, he was summoned to Chief Grabowski's office and informed he was not to come back to work until he had been cleared by Dr. McManus, the psychologist Respondent selected to treat the firefighters involved in the March 30, 2010 fire. T.79.

On April 20, 2010, Petitioner sent an email to Chief Grabowski. This was admitted as Petitioner's Exhibit 6 and reads, in relevant part, as follows:

> In the days that followed the death of FF Carey on March 30, 2010 there were various CISD meetings that I attended. Durring (sic) these sessions there was discussion among the participants that prior to returning to active duty we would have to each meet individually with a psychiatrist that the Village would be providing. However at no time during this was there any official word or notice given by yourself or any other representative of the department…

> On April 12, 2010 I sent an email to Deputy Chief Johnson requesting the name and number of the chosen pschiatrist (sic). I knew that the other effected (sic) individuals were meeting with the psychiatrist the next day. Since I didn't have to be at the hospital for a medical procedure untill (sic) 3:00 I wanted to attempt an initial consultation. I received an email from DC Johnson denying my request and telling me nothing would be done until after my procedure.
>
> Subsequently on April 27, 2010 (sic) I again emailed DC Johnson for the information. As of this email I have received no response from him.
>
> In the interest of preserving my mental status and recognizing the signs of PTSD I have arranged to begin seeing Dr. Marc Slutsky. PX8.

Chief Grabowski responded within 30 minutes:

> I have forwarded your E-Mail to D/C Johnson. We only received word yesterday that you were able to see Dr. McManus. He has been notified and we are awaiting his call. As soon as we can get you in we will…As soon as we here (sic) from Dr. McManus you will be notified. It is important that you seek help as needed and D/C Johnson will be available to help with whatever your needs are….PX9.

On April 23, 2010, Petitioner was evaluated by Dr. McManus. PX6. Dr. McManus' notes from that therapy session indicate Petitioner voiced "a mixture of feelings that included guilt about the fire, the burden of his responsibility as supervisor for the death, and feeling abandoned by his supervisors." PX6. He reported sleep difficulties, with dreams about the event. PX6. Dr. McManus diagnosed acute stress disorder. PX6.

Petitioner testified his treatment with Dr. McManus consisted of talking about the effects of the fire as well as his difficulty sleeping and the fact he was having flashbacks of the fire.

The evidence deposition of Dr. McManus was admitted as Petitioner's Exhibit 13. Dr. McManus testified about the progression of his sessions with Petitioner. Dr. McManus explained Petitioner was initially very guarded and it was very difficult to engage him in the therapeutic process. PX13, p.16. Things changed, however, as of the May 14, 2010 session. Dr. McManus testified he and Petitioner had a discussion about comments Petitioner made on Facebook regarding therapy, and Petitioner expressed his frustration at the generalized approach to the doctor's questions; Petitioner advised he would find it more helpful if the doctor were more exact in questions and would provide more direction in terms of treatment. PX13, p.19-20. Dr. McManus testified that session was a turning point in Petitioner's therapy and the sessions thereafter were much more productive. PX13, p.20-21.

Dr. McManus detailed Petitioner's improvement through therapy over the next weeks. During the May 28, 2010 session, a video of the fire was reviewed. Dr. McManus explained the

purpose of this was to determine what extent viewing the event would impact Petitioner symptomatically. PX13, p.23. The doctor stated this was done to monitor Petitioner's progress with respect to potential return to work. PX13, p.23. Dr. McManus testified Petitioner was able to separate his emotional responses to the fire, meaning his sadness and guilt about the loss of a colleague, versus his reaction to the administrative side, and this allowed Petitioner to manage the emotional aspect more effectively. PX13, p.24-25. Noting Petitioner's continued improvement, Dr. McManus administered a Personality and Assessment Inventory at the next session; Dr. McManus testified the results were promising:

> ...the test results indicated that he had experienced a traumatic event, there was mild distrust as I recall of the process but that he was actually showing good control over anxiety, good control over mood, good control over any depressive affect, and that he had made sufficient progress at that point to consider returning to work, which was discussed two weeks later. PX13, p.26-27

On June 14, 2010, Dr. McManus released Petitioner to return to work; Dr. McManus explained the release was conditioned on Petitioner's continued participation in therapy. PX13, p.27.

Regular therapy sessions continued through December, with the last being December 21, 2010. Dr. McManus described Petitioner's condition at that time:

> Well, I felt that he continued to show a steady emotional state, a steady cognitive state, a steady affect of arousal state after being back to work for approximately five to six weeks and that he felt comfortable at work, he felt comfortable with his work performance, he felt like he had the adjustment period, let me change that, the transition period back to work had been successful for him. He was generally feeling comfortable within the firehouse and that he was in a good position where we could terminate treatment at that time. PX13, p.38-39.

Dr. McManus advised Petitioner to return should he re-experience symptoms or have any emotional difficulties related to his job performance.

Dr. McManus testified Petitioner did return for an additional session on January 11, 2011. Petitioner reported there were numerous reminders of Firefighter Carey in the firehouse which were creating a lot of memories for him, but he felt it would not be received well by his colleagues if he attempted to speak to them about his feelings. PX13, p.41-42. Dr. McManus testified he advised Petitioner his responses were normal and reviewed thought-stopping exercises with him. PX13, p.42.

The evidence deposition of Dr. Marc Slutsky was admitted as Petitioner's Exhibit 14. Dr. Slutsky evaluated Petitioner on three occasions: May 4, 2010; February 8, 2012; and November 2, 2012. Dr. Slutsky testified as to Petitioner's mental state during those evaluations:

17IWCC0484

> When I first met him in 2010 his almost consummate focus was on the terror, the fear, the anxiety, the panicky states, as I described.
>
> When I then saw him in February of 2012, he gave evidence of attempting to establish rapport and to try to put some perspective on his concern about his symptoms but at the same time to convey to me that he had developed a significant improvement in his executive function, his ability to frame, to think, to conceptualize, to respond, even though he had described tremendous elements of irritability, difficulty relating, isolation, flashbacks, and other symptoms.
>
> When I saw him in November of 2012, he had indicated at that point that both by his demeanor, his presentation, his mental status, and by what he chose to talk about, that he was getting more of a handle on these different symptoms. They were present but in a more encapsulated way. PX14, p.13-14.

Petitioner testified he continues to work as a lieutenant for the Village of Homewood. T.87. He has performed his job functions and been on numerous fires and emergency medical calls since returning to work. T.90. Of those calls, some were structure fires, some were house fires, and some were hotel fires; Petitioner testified he performed all his job duties at those fires. T.128-129. He further testified he has not reported any complaints about his job duties or problems performing his job. T.129.

As to his current symptoms, Petitioner testified he continues to have multiple flashbacks on a daily basis. T.88. Petitioner explained he combats these episodes by trying to keep his mind busy, particularly when he is at work: "…I find that if I'm occupied on something else it doesn't allow my mind time to just think what it wants to if I can focus on certain things." T.138. Petitioner also testified he began having difficulty sleeping after the fire and doesn't sleep much anymore. T.88. The problem exists regardless of whether he is trying to sleep at the firehouse or at home. T.88.

Conclusions of Law

I. Notice:

Section 6(c) requires notice be given no later than 45 days after the date of the accident. *820 ILCS 305/6(c)*. The purpose of the Act's notice requirement is to enable employers to investigate alleged accidents; a claimant complies with the Act if, within 45 days, the employer possesses the known facts related to the accident. *S&H Floor Covering, Inc. v. Illinois Workers' Compensation Commission*, 373 Ill. App. 3d 259, 264-265, 870 N.E.2d 821 (2007).

Respondent's challenge to notice is predicated on its position no accidental injury occurred. In other words, Respondent argues no proper notice of an accident could be provided

because there was no accident. As the accident issue was resolved in Petitioner's favor, Respondent's notice argument necessarily fails.

The Commission further notes Petitioner's April 20, 2010 email to Chief Grabowski documents Petitioner's multiple requests for a consultation with the Village's psychologist and closes with, "In the interest of preserving my mental status and recognizing the signs of PTSD I have arranged to begin seeing Dr. Marc Slutsky." PX8. The Commission finds this email, sent well within the 45-day window, provided Respondent with the "known facts related to" Petitioner's psychological accident. As such, the Commission finds Petitioner provided timely notice.

II. TTD/Credit:

As a full-time firefighter for the Village of Homewood, Petitioner is an "eligible employee" under the Public Employee Disability Act ("PEDA"). See *5 ILCS 345/1(a)*. (For the purposes of this Section, "eligible employee" means…any full-time law enforcement officer or full-time firefighter who is employed by…any unit of local government….) Section 1(b) of the PEDA provides, "Whenever an eligible employee suffers any injury in the line of duty which causes him to be unable to perform his duties, he shall continue to be paid by the employing public entity on the same basis as he was paid before the injury…" *5 ILCS 345/1(b)*. Section 1(d) additionally states, "Any salary compensation due the injured person from workers' compensation…shall revert to that entity during the time for which continuing compensation is paid to him under this Act." *5 ILCS 345/1(d)*.

On the Request for Hearing, the parties stipulated Petitioner was off work April 8, 2010 through June 20, 2010, a period of 10 $^{3}/_{7}$ weeks. The parties further stipulated Petitioner received full salary during this period pursuant to PEDA. The parties stipulated $7,477.30 was paid to Petitioner for TTD benefits. ArbX1.

The Commission finds Petitioner entitled to TTD benefits from April 8, 2010 through June 20, 2010, with Respondent entitled to a credit for all amounts paid.

III. Nature and Extent

Following the events of March 30, 2010, Petitioner attended regular therapy sessions with Dr. McManus through December of 2010. There was an additional session with the doctor in January of 2011, but he has not returned thereafter. Petitioner further stated he has no appointments scheduled with any psychiatrist or psychologist. T.86, 124.

Petitioner returned to work at his pre-accident position of paramedic/lieutenant. Since returning to active duty, he has responded to numerous fires and emergency medical calls, and he testified he performed all his required functions without problem. T.90, 128-129.

Petitioner continues to experience symptoms of PTSD. He described recurring flashbacks which occur multiple times per day:

> There's two that are very predominant that I get. One of them is when they brought Brian out. I see that one a lot. There's another one where they're taking him on the stretcher. There are ones of at his services.
>
> There's about six or seven different ones that just pop in and out at various times during the day. There's nothing that sets them off. There's nothing that I can do or not do to stop them. They just - - sometimes it's a couple an hour, sometimes it's three of four hours. But it's just a randomized thing that occurs. T.136.

Petitioner additionally continues to have difficulty sleeping and testified he "doesn't sleep much anymore." T.88.

Having reviewed the evidence in its entirety, the Commission finds Petitioner sustained permanent partial disability to the extent of 7.5% loss of use of the person as a whole under Section 8(d)2. The parties stipulated Petitioner's average weekly wage is $1,706.77. ArbX1. Calculated pursuant to Section 8(b)2.1, Petitioner's PPD rate exceeds the statutory maximum in effect for the March 30, 2010 accident date: $664.72 ($1,706.77 x 60% = $1,024.06). As such, the Commission awards Section 8(d)2 benefits of $664.72 per week for 37.5 weeks, representing a 7.5% loss of use the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that, pursuant to the order of the First District Appellate Court, the Commission finds Petitioner sustained an accidental injury arising out of and in the course of his employment with Respondent on March 30, 2010, and his post-traumatic stress disorder is causally related to his work injury.

IT IS FURTHER ORDERED BY THE COMMISSION that notice was timely provided by Petitioner.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $1,137.85 per week for a period of 10 $^{3}/_{7}$ weeks, that being the period of temporary total incapacity for work under Section 8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay Petitioner the sum of $664.72 per week for a period of 37.5 weeks, as provided in Section 8(d)2 of the Act, for the reason the injuries sustained caused 7.5% loss of use of the person as a whole.

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

17IWCC0484

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.

Under Section 19(f)(2), no "county, city, town, township, incorporated village, school district, body politic, or municipal corporation" shall be required to filed a bond. As such, Respondent is exempt from the bonding requirement.

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

DATED: AUG 2 - 2017

L. Elizabeth Coppoletti

LEC/mck

Charles J. DeVriendt

D: 6/6/17

43

Joshua D. Luskin

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 down	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

JAMES GRIFFETH,

Petitioner,

vs. NO: 15 WC 12818

R.W. DUNTEMAN CO.,

Respondent.

17IWCC0485

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 prospective medical care, and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to Thomas v. Industrial Commission, 78 Ill.2d 327, 399 N.E.2d 1322, 35 Ill.Dec. 794 (1980).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Commission finds:

1. Petitioner is a Machine Operator running highway construction machinery. On April 2, 2015 he was working on an asphalt plant getting it ready to fire up for the year. While working, a pipe cap exploded in his face, knocking out some of his teeth.

2. The pipe cap is the cap of an AC tank. The bottom of the tank has coal tar and there are pipes filled with oil. There is a heater which heats the oil, which causes pressure, and ultimately forced the cap to explode.

3. After the explosion, Petitioner's mouth was bleeding profusely. He covered his mouth with his hand and spit out some teeth. He claimed he had two teeth out and three teeth chipped. He admitted to having some discolored teeth prior to the accident.

4. Petitioner was taken to the hospital and received stitches and pain medication. It was noted that he had suffered two broken front teeth. An examination of the photos taken that day reveal that these two teeth are on Petitioner's bottom row. Further examination reveals that there was a small, but still noticeable chip on one of Petitioner's teeth on the upper row (Tooth #9). None of the remaining upper row teeth visible in the photos appear to show any trauma-related disfigurement.

5. Petitioner then visited with an oral surgeon who removed a couple of his teeth. He was then referred to another dentist who recommended extraction of four teeth because they had a good chance of dying. The surgeon then recommended dental implants.

6. Petitioner had not seen a dentist in quite some time prior to the accident in question. After the accident he was told that there was significant decay in his mouth that was unrelated to the accident.

7. Dr. Bargamian examined Petitioner's records and opined that teeth #'s 7 and 10 were not damaged periodontally.

The Commission affirms the Arbitrator's causal connection opinion in relation to tooth #9 on Petitioner's upper row. However, the Commission reverses the Arbitrator's finding of causal connection in relation to teeth #'s 7, 8 and 10. Petitioner had pre-existing tooth decay on the top row of teeth which accounted for the majority of his disfigurement. As noted by Dr. Bargamian, if Petitioner's current upper teeth conditions were the result of the accident related trauma, there would be injury to the adjacent soft tissue, of which there is little to none present in the photos. For perspective, photos show that Petitioner's lower lip is clearly damaged, which is consistent with the (stipulated) trauma-induced structural damage to teeth #22-27 on the bottom row.

The Commission agrees with the Arbitrator's finding with relation to tooth #9. Despite Dr. Bargamian's argument, it cannot be denied that there is a noticeable chip on tooth #9, which does not seem to show any real evidence of decay. The Commission concludes that this chip is the result of the work related accident. Accordingly, the Commission affirms the Arbitrator's causal connection finding, but only with respect to tooth #9.

17IWCC0485

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's chipped tooth #9 is causally related to the work accident.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is liable for all reasonable and necessary medical expenses related to treatment for tooth #9, under §8(a) 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 $5,600.00. 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 - 2017
O: 6/8/17
DLG/wde
45

David L. Gore

Stephen Mathis

Deborah L. Simpson

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

GRIFFETH, JAMES
Employee/Petitioner

Case# **15WC012818**

R W DUNTEMAN COMPANY
Employer/Respondent

17IWCC0485

On 11/10/2016, 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 0.53% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1727 LAW OFFICE OF MARK N LEE
KEVIN MORRISON
1101 S 2ND ST
SPRINGFIELD, IL 62704

0560 WIEDNER & McAULIFFE LTD
BRIAN J KOCH/MATT J ROKUSEK
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

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)

James Griffeth
Employee/Petitioner

v.

R.W. Dunteman Company
Employer/Respondent

Case # 15 WC 12818

Consolidated cases:

17IWCC0485

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 **Springfield**, on **9/29/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **4/2/2015**, 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 **$Reserved**; the average weekly wage was **$Reserved**.

On the date of accident, Petitioner was 45 years of age, ***single*** with **0** dependent children.

Petitioner has not received all reasonable and necessary medical services.

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

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

ORDER

Respondent shall pay reasonable and necessary medical services, as provided in Sections 8(a) and 8.2 of the Act and per the stipulation of the parties, subject to any credit pursuant to Section 8(j).

Petitioner was successful in proving his current condition of ill-being in the disputed teeth #7, #8, #9, and #10 are causally related to his work accident, and that the extraction of teeth #7 and #10 were reasonably required to cure or relieve the effects of his work accident. The past and prospective treatment of Teeth #22-27 were stipulated as causally related by the parties prior to trial.

Respondent shall authorize and pay for prospective medical treatment including, but not limited to, the proposed implants/bridges for teeth #6-8 and #9-11 as well as teeth #22-27 proposed by Dr. Matthew Lynch.

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

11/5/16
Date

ICArbDec19(b)

NOV 10 2016

Pre-Trial note

Pursuant to an agreement of the Parties Petitioner made an oral motion to amend their Application for Adjustment of Claim and changed the name of the identified Respondent from "Du-Kane Asphalt" to "R.W. Dunteman Company."

Statement of Facts

Mr. James Griffeth was employed by the Respondent on April 2, 2015. During that time he testified he was struck in the face by a silver cap pictured in Petitioner's Exhibit 1. The Petitioner testified that immediately after being struck he noticed blood and spit out pieces of broken teeth. Petitioner denied any prior teeth pain and never had a dentist recommend removal of any of his teeth prior to April 2, 2015. Petitioner did admit that prior to the April 2, 2015 accident had not seen a dentist for a very long time. Petitioner also admitted that his teeth were decayed prior to the accident but suffered no pain or discomfort in them but that after the accident all of his teeth were in a great deal of pain.

Petitioner then treated medically at Pana Community Hospital on April 2, 2015. The nurse's note from his visit noted; "Ambulatory with cloth and pressure to mouth. States he was at work and a pipe came up hitting me in the mouth, knocking my teeth out. Broken teeth X2 front middle noted laceration to chin..." (PX-2) Respondent entered in pictures of Petitioner teeth taken at Pana hospital. The multiple pictures of his mouth show the two top teeth being black and decayed but broken to some extent and the bottom teeth broken in half. It was also noted that the Petitioners' front tooth had a chip out of it that Petitioner claimed was a result of the trauma.

Petitioner was instructed to follow up with Dr. Harrington on April 2, 2015. The record from Dr. Harrington's office was difficult to read but instructed Petitioner to see an oral surgeon. Petitioner testified that he did not return to Dr. Harrington because his office insisted he pay on the date of treatment out of his own pocket and upfront. The bill from Dr. Harrington's office in Petitioner's Exhibit 7 collaborates this testimony.

Petitioner followed up with Dr. David Fisher at Springfield Maxillofacial on May 19, 2015. It was noted that the Petitioner came in for an evaluation and extraction of teeth #24 &25. The patient states significant discomfort in the lower anterior teeth, but also occasional radiating pain in the upper anterior as well. It was noted that he suffered severe decay on multiple teeth. Under the assessment/plan portion of the record it noted that the Petitioner is a 45-year old male status post blunt trauma on April 2, 2015, suffering sublaxation and concussion of teeth #s 6 through 11 and 22 through 27 with also a fracture of teeth #'s 24 &25. Dr. Fisher recommends that he follow up with Dr. Harrington office to formulate a plan to restore the teeth in question. But he would need vitality testing on teeth #'s 6 through 11 and the lower anterior teeth in the near future. (PX 4)

Petitioner then followed up with a second dentist, Dr. Matthew Lynch, on May 20, 2015 who noted that the Petitioner had a work accident and discussed option for repair. Dr. Lynch noted that

teeth #23-26, #7 and 10 was due to a possible loss of vitality/cracks from trauma and suggested bridges to replace missing teeth. Petitioner was then to follow up with an oral surgeon.

Respondent then requested a record review from a Dr. Bargamian. (RX-2) It was noted by the Arbitrator that this was a record review and Dr. Bargamian did not personally see the Petitioner or exam his mouth in person. Dr. Bargamian agreed that the extraction and rehabilitation of teeth #23, #24, #25, and #26 was causally related to this claim. However, regarding teeth #7 and #10, Dr. Bargamian noted that Petitioner suffered from severe multi-surface tooth decay in the pictures and surrounding teeth and agreed that teeth #7 and #10 should have been removed but it was due to their advanced decay not the accident in question. Dr. Bargamian further opined that he did not believe teeth #7 and #10 were damaged as a result of the trauma. He based this opinion on the fact that the teeth adjacent to teeth #7 and #10 were not damaged.

Dr. Matthew Lynch then noted that the Petitioners' teeth #7-10 were carious and broken. Teeth #7-10 were recommended for extraction due to severe carious, percussion sensitivity, loss of tooth structure, and long term prognosis of endodontic were performed. Dr. Lynch recommended bridges for #6-8, and #9-11 to strengthen and stabilize the teeth adjacent to trauma in addition to replacing teeth. He also offered implants as an alternative. Dr. Lynch concludes that while the Petitioner's teeth were carious and would require treatment at some point, he had no pain in his teeth prior to the accident. (PX-6)

Petitioner submitted a photo which he estimated was 6 months to a year prior to the accident but could not give a date showing his teeth. Petitioner testified that his teeth did not have any change to from the time of the picture to the date of the accident. The picture is not up close and it is difficult to tell if there was decay present or not.

Petitioner did not allege any time loss due to the accident and is currently employed.

Conclusions of Law

The Arbitrator finds in favor of the Petitioner and order that the Respondent provide prospective and already incurred dental care in regarding to teeth #6-#8 and #9-11 to be causally related to his injury. As per the stipulation of the parties, the Arbitrator further orders that the Respondent pay for teeth the repair, past/present, and restoration of teeth #22-27 and makes no findings of law regarding these teeth as they were stipulated to as causally related at the time of trial. The findings of law are in regards to the treatment and prospective care of teeth #6-8 and #9-11.

To be entitled to compensation for an injury, Petitioner need not prove that the injury was the sole causative factor in his subsequent treatment and disability, but only that it was a causative factor. If a pre-existing condition is aggravated, exacerbated, or accelerated by an accidental injury, the employee is entitled to benefits. Rock Road Construction v. Industrial Commission, 37 Ill.2d 123,227 N.E.2d 65, 67-8 (1967) It was undisputed at the time of trial that the Petitioner's teeth were decayed prior to the date of injury but the Petitioner had no pain or never sought treatment for his teeth prior to being struck in the face. Post injury, Petitioner complained of pain in both parts of his mouth and it was

noted by the Arbitrator that the pictures of his mouth taken immediately post injury showed that the teeth in question were damaged structurally. Petitioner's un-rebutted testimony was that those teeth were whole prior to his injury.

The Arbitrator does recognize the arguments of Dr. Bargamian; the treatment in question is not likely related to trauma due to the fact that those teeth were not struck in the accident but due solely to the fact that the Petitioner suffered from advanced dental decay. However, the Arbitrator finds that argument to be unpersuasive. Dr. Bargamian did not exam Petitioner's mouth and there is enough medical documentation that the Petitioner suffered injury to the upper part of his mouth to dispute the assertion he suffered no trauma to that portion of his mouth. The ER records from Pana hospital noted that Petitioner suffered two broken upper teeth upon arrival. Also Petitioner testified that the chip in his front tooth was a result of the accident showing that the upper portion of his mouth did suffer trauma as a result of this accident. The pictures of the Petitioner's mouth taken the same day as the injury demonstrates a fair amount of decay but it also demonstrates a noticeable loss of tooth structure which Petitioner claimed came about as a result of his work injury. Further, Dr. Lynch did recognize that the Petitioner suffered from severe decay in his teeth and he recommended treatment for that in addition to damage secondary to trauma. Dr. Lynch also felt it was relevant that the Petitioner suffered no pain complaints prior to the accident and part of his treatment plan relied on Petitioner's continued pain complaints.

Accordingly, the Arbitrator concludes that the Petitioner's April 2, 2015 accident aggravated, accelerated a pre-existing condition of ill-being to Petitioner's upper teeth which resulted in the need for treatment after that date and future treatment to correct his dental issues.

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

Mark Hart II,

Petitioner,

vs. NO: 14WC 21185

Speedway Auto Salvage,

Respondent.

17IWCC0486

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent, herein and notice given to all parties, the Commission, after considering the issues of accident, causal connection, prospective medical and temporary total disability, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. The Commission 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 June 13, 2016, 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.

17IWCC0486

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 $27,400.00. 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 4 - 2017
MJB/bm
o-7/25/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

HART II, MARK
Employee/Petitioner

Case# **14WC021185**

SPEEDWAY AUTO SALVAGE INC
Employer/Respondent

17IWCC0486

On 6/13/2016, 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 0.43% 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
RICHARD E SALMI
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HTS, IL 62208

2795 HENNESSY & ROACH PC
KATHERINE WHITAKER
415 N 10TH ST SUITE 200
ST LOUIS, MO 63101

STATE OF ILLINOIS)
)SS.
COUNTY OF Jefferson Co.)

☐ 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)

Mark Hart II
Employee/Petitioner

v.

Speedway Auto Salvage
Employer/Respondent

Case # 14 WC 021185

Consolidated cases: N/A

17IWCC0486

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Michael Nowak**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **12/2/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0486

FINDINGS

On the date of accident, **6/1/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$29,488.27**; the average weekly wage was **$567.08**.

On the date of accident, Petitioner was **34** 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 **$2,400.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$2,400.00**.

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

ORDER

Respondent shall pay reasonable and necessary medical services of $15,891.29, as set forth in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the medical treatment recommended by Dr. Keith Wilkey, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $378.05/week for 78-4/7 weeks, commencing 6/1/14 through 12/2/15, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $2,400.00 for temporary total disability benefits that have been paid.

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

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

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

Michael K. Nowak, Arbitrator

5/26/16
Date

ICArbDec19(b)

JUN 13 2016

17IWCC0486

FINDINGS OF FACT

Petitioner, a 36 year old male began work for Respondent in July of 2010. Prior thereto he had worked on and off for Respondent. (T.10). His job was to remove parts such as alternators, water pumps, motors, catalytic converters, and transmissions from salvaged cars and he later also became a tractor driver and managed the yard. (T.11). Prior to June 1, 2014, he had no problems with his left arm or neck and was able to perform all of his work duties without limitations. (T.12). Petitioner's testimony in this regard was confirmed by one of Respondent's managers, Rodney McQuaid (T.55) and the owner, Francis Henky.

On the date of the accident, Petitioner was removing a part from the underside of a vehicle which was sitting on a metal rack which was located over a pit. As he was coming out from under the vehicle he struck his head on the metal bar of the rack. (T.13). Petitioner explained he was carrying a part at the time and thought he had ducked under the bar of the rack. When his head struck the rack it "kind of shoved his head down" and it was bleeding on top. As Petitioner was walking away from the rack Frank, one of Respondent's managers, was walking toward him. Petitioner testified Frank noticed the blood and Petitioner told him what had happened. It was Petitioner's unrebutted testimony that Frank asked him if he wanted to fill out paperwork or if he wanted to go to the hospital, but Petitioner did not think it was that bad, just a stiff neck.

Petitioner completed his shift on the date of accident. When he awoke the following day his arm was hurting and his neck sore, so he phoned and talked to Rick, one of Respondent's assistant managers. He advised he was not going to be able to make it in. (T.15). Petitioner testified he called off work the next day as well, speaking the secretary, Theresa. He testified he told Teresa that he was not feeling any better. (T.16). He testified that he called in on the third day and asked if he could come by and pick up his pay check. He went in and spoke to Rodney who told him that he needed to talk to Francis. (T.16). He testified that as soon as Francis saw him he threw his pay check at him and told him that he was fired. Petitioner attempted to explain that he had been hurt and Francis said he did not want to hear any excuses. (T.16). Apparently Respondent had fired and rehired Petitioner a number of times in the past, so Petitioner called Francis the day after he was fired and asked if he was seriously fired. He testified that he told Francis that he was going to the emergency room during that conversation.. (T.39).

Petitioner testified that he was later asked to return to work in his previous position, but he is not able to go back until the doctor releases him. (T.29). He has not done any work for cash since the date of the accident. Since the accident he lost his vehicle and home and has had to alternate living with his mother and mother-in-law. He candidly testified that he helps them out by raking the yard or painting, all of which he can do at his own pace. (T.19-20). He has trouble using his left side for more than about 10 or 15 minutes at a time without it really throbbing or aching, so he has to pace himself. (T.20). Petitioner testified that he would return to work for Respondent if he could. He does not have a high school diploma or a GED. Petitioner testified he missed two medical appointments due to finances and having lost his car. He now has a medical card from the state and relies on food stamps. (T.44).

Petitioner reported to Gateway Regional Medical Center with problems with his neck and left shoulder on June 6, 2014, just 5 days post-accident. (T.17). He was given some pain killers, muscle relaxers, and anti-inflammatories for the throbbing pain in his neck and shoulder and later he started getting a little tingling down his arm and his pinky and ring fingers. (T.18). He believes someone at the emergency room noted the scab on

his head. (T.40). He thinks she mentioned a slight concussion. (T.40). The Gateway Regional Medical Center record of June 6, 2014 documents complaints of contusion, decreased range of motion, and injury. (Px2:23). The history indicates the incident occurred six days ago and was sustained at work. (Px2:23). The injury resulted from walking into a car lift at work, was ducking to walk under the lift and struck his forehead on the metal frame, and complained of pain that worsened over the past three days, was using Icy Hot without relief. (Px2:23). Review of systems was positive for pain at rest and with movement of the posterior cervical area and left trapezius. (Px2:23). His neurologic exam was negative for numbness, tingling and weakness. (Px2:23). He complained of pain in the left shoulder and lower neck. (Px2:26). He was prescribed Naprosyn, Norco, Valium, and Baclofen. (Px2:22).

Petitioner presented to Dr. Stephen Woods on June 17, 2014. He reported an injury while working for Respondent where he suffered an injury to his head, neck, and upper back. (Px3:2). While under a vehicle rack he stood up and hit his head and felt that he jammed his neck. (Px3:2). He states his supervisor saw what had occurred and inquired about the injury. (Px3:2). He denied any history of prior symptoms similar to his current complaints and was symptom free at the time of the accident on June 1, 2014. (Px3:2). Neurological evaluation revealed increased sensitivity from the left upper back and down the left shoulder, arm, and left hand to the third through fifth fingers. A Post Concussion Symptom Questionnaire revealed post-concussive injury. (Px3:3). Dr. Woods diagnosed mild traumatic brain injury, cervical radiculopathy in the left upper extremity, suspicion of cervical disc disruption and cervical spine sprain and strain. (Px3:4). A course of conservative treatment and an MRI were recommended. Petitioner was to remain off work. (Px3:4).

On June 25, 2014 an MRI of the cervical spine was performed at Greater Missouri Imaging. (Px6:7). According to the radiologist, the MRI revealed mild disc desiccation with diffuse annular disc bulge at C6-7 on the left and no other significant disc profile abnormality. (Px6:7). Dr. Matthew Ruyle reread the MRI on July 9, 2014 and concluded that it shows a C6-7 central broad-based 3 to 3.5 millimeter herniation resulting in dural displacement. (Px6:10).

Petitioner saw Dr. Keith Wilkey for evaluation on June 26, 2014 and has continued treating with Dr. Wilkey to the present. (Px7). The history to Dr. Wilkey indicates Petitioner struck his head on the undercarriage of a car while working on it, developing onset of neck and left radicular complaints. (Px7:2). Physical exam revealed tenderness to palpation in the left trapezius, posterolateral portion of the left arm and into the hand; positive Spurling's Test; diminished motor and sensory exam to light touch sensation in the C7 distribution with notable weak triceps and wrist flexor. (Px7:3). The assessment was post-concussive syndrome, left arm radiculopathy and probable herniated disc on the left at C6-7. (Px7:3). When Petitioner returned on July 24, 2014, he continued to have arm and neck complaints and his left hand was still numb and weak, but improved. He had limited cervical range of motion; weakness to the triceps and diminished light touch sensation in the C7-T8 distibution. (Px7:4). The assessment remained left arm radiculopathy, cervical herniated disc at C6-7 and ulnar nerve neuritis. (Px7:4). Petitioner returned on September 10, 2014, he had made some improvement, but exam showed continued diminished light touch sensation to the C7 dermatome pattern and a positive Spurling's test. (Px7:5). On December 18, 2014, Petitioner described pain, numbness, and weakness down the left arm with some improvement in his headaches. (Px7:6). Physical exam revealed symptoms and findings in a radicular pattern along with weakness of the triceps and a positive Spurling's test. (Px7:6).

On January 29, 2015, Dr. Shekhani performed a cervical epidural steroid injection at C6-7 and the assessment was cervicalgia, cervical radiculopathy and post-concussion syndrome. (Px8:7). He saw Dr. Shekhani in follow up on February 26, 2015 with continued headaches and neck and left upper extremity symptoms. (Px8:6). Trigger point injections were administered bilaterally at C5 and C7. (Px8:6).

Petitioner followed up with Dr. Wilkey on June 11, 2015, July 9, 2015, August 6, 2015 and September 8, 2015. Petitioner's condition had not changed. His continued assessment remained left arm radiculopathy with acute cervical disc herniation at C6-7 and a continued off work status. (Px7:10-11). Since May 7, 2015 Dr. Wilkey has been awaiting approval for surgery. (Px7:13).

Dr. Wilkey testified by deposition. The history of injury is consistent with the treatment records of Gateway Regional Medical Center and the mechanism of injury is consistent with what Petitioner described to him. (Px1:8). Dr. Wilkey testified the worsening of symptoms over the course of a few days after the accident leading him to seek out medical treatment is consistent with the nature of his injury. (Px1:8). Dr. Wilkey concluded that Petitioner has a herniated disc to the left at C6-7 with a left arm radiculopathy. (Px1:8). Initially, people will have midline pain, and then develop radicular or more appendicular complaints hours to days after the injury, so this presentation of injury and development of symptoms fits the described mechanism of injury. (Px1:9).

Dr. Wilkey testified Petitioner's subjective complaints were consistent with the objective findings. He explained that Petitioner described pain on his left trapezius, the back portion of his left arm, down into the hand and when he tipped his head and rotated his head to one side, it caused pain down his arm, a finding consistent with somebody who has a pinched nerve in their neck. (Px1:10). Physical exam showed further symptoms consistent with his injury, including weakness of his triceps and wrist flexor. (Px1:10). He also had numbness in the C7 nerve root distribution, the index, middle, and ring finger of the left hand, indicating the nerve is irritated and fits the pattern of his diagnosed injury. (Px1:10). His diagnosis is acute left arm radiculopathy and herniated disc. (Px1:11).

Physical exam consistently showed weakness of the triceps, diminished light touch sensation in the C6-C8 distribution. (Px1:12). Dr. Wilkey confirmed there was clinical evidence of arm radiculopathy from the first evaluation by Dr. Wilkey and the diagnosis was borne out by the earliest imaging as well. (Px1:39). Dr. Wilkey was able to diagnose the C6-7 herniation from his physical exam findings and history, making this a pretty clear cut situation. (Px1:40).

Dr. Wilkey confirmed the June 25 MRI shows a disc herniation at C6-7 causing the left-sided foraminal stenosis. (Px1:13, 36). Petitioner's physical exam findings continued to be consistent with the diagnosed injury, the triceps were weak, there was a positive Spurling's test and there was concordant pain down the left arm to his hand. (Px1:14). The next step in the treatment plan was epidural injections. (Px1:14-15). Petitioner had some improvement from the injection by Dr. Shekhani for about a week, confirming the diagnosis and the needed cure. (Px1:16-17). When Dr. Wilkey saw Petitioner in March 2015, Petitioner continued to have confirmatory physical exam findings. (Px1:18). Dr. Wilkey recommends surgery and is waiting for workers' compensation approval since conservative treatment failed. (Px1:18). Dr. Wilkey recommends an anterior cervical decompression and fusion, a standard surgery that is done for somebody with a disc herniation and arm radiculopathy. (Px1:19) Dr. Wilkey has continued to see Petitioner in follow up and Petitioner continues to

have weakness in the triceps, numbness in the outer portion of the fingers and a positive Spurling's test which have all been consistent all along. (Px1:19). The symptoms and objective findings all remained consistent over the course of time. (Px1:20). Dr. Wilkey indicated Petitioner has done everything that has been asked of him and Dr. Wilkey believes he will respond well to surgery. (Px1:21). Dr. Wilkey believes Petitioner is a person who has been a working man his whole life and lives hand-to-mouth. (Px1:22). Dr. Wilkey notes Petitioner's hands are usually dirty, his clothes are dirty, his face is dirty and he is a fairly unkempt individual. (Px1:37). But Petitioner's ability to perform some occasional activities does not contradict the MRI findings, does not contradict the results he had from the injection and Dr. Wilkey believes Petitioner's need for surgery is supported by the objective findings. (Px1:22). Petitioner is not at MMI for his work injury and he needs continuing work restrictions until surgery is completed. (Px1:22-23). Six weeks after his surgery Petitioner will most likely be able to return to full duty with no restrictions and would probably be at MMI within three to six months from the time of his surgery. (Px1:23).

On March 20, 2015 Petitioner was examined by Dr. R. Peter Mirkin pursuant to §12 of the Act. Dr. Mirkin testified by deposition as well. At his evaluation, Petitioner made it clear that he did not want to fill out any paperwork which consisted of five pages of written questions. (RxD:29). Dr. Mirkin confirmed he asked many of the same questions as on the questionnaire and Petitioner answered all of his questions. (RxD:29). Dr. Mirkin was able to perform a physical examination and reviewed the medical treatment records provided by Respondent regarding treatment for the work injury. (RxD:29). Dr. Mirkin noted Petitioner's hands were covered in grease and dirt with thick callouses on both palms. (RxD:14). Dr. Mirkin believes Petitioner has subjective symptoms that possibly could indicate surgery, but he believes they are far out of proportion to what they should be and there are signs he has been doing heavy activity with his upper extremities, such that Dr. Mirkin cannot recommend surgery based on the information he has available. (RxD:22). A disc herniation can result in symptoms from nothing, to pain in the neck, to radiculopathy where there is pain in the pathway of the nerve. (RxD:23). The radiologists had a slight difference in semantics in the reading of the MRI. (RxD:26). He believes one doctor's reading interpreting a bulging versus a 3 to 3.5 millimeter herniation can be the same thing as there is no accepted nomenclature for saying at what point a bulge becomes a herniation or protrusion, a lot of people use them interchangeably. (RxD:27). Both of the radiologists identified pathology at the C6-7 level. (RxD:26). Dr. Mirkin stated there is no way to tell whether this herniation was caused by an acute injury. (RxD:17). The accident may have caused or aggravated his condition of strain and may have even caused a little bulge in his disc since there is no pre-existing MRI scan but Dr. Mirkin believes he does not have any radicular signs. (RxD:18). If Petitioner continued to complain of arm symptoms, Dr. Mirkin would recommend an EMG and nerve conduction study to determine whether he has any nerve abnormality in the arm or not. (RxD:19). Dr. Mirkin is of the opinion that Petitioner should be able to do his regular work without restrictions. (RxD:22). Dr. Mirkin is familiar with Dr. Wilkey and agrees the medical records indicate Petitioner sustained an injury to his neck when he struck his head at work. (RxD:28). He further agreed striking one's head can result in injury to the cervical spine. (RxD:28).

Dr. Mirkin agreed that Petitioner did not have any prior neck or arm problems. (RxD:31). Petitioner's current complaints include neck pain and inability to use the left arm. (RxD:31). Those are the types of symptoms which can be caused by striking one's head. (RxD:32). A disc herniation at C6-7 on the left would not prevent one from using an arm but there would be specific findings such as absent reflex in the triceps, weakness in the triceps, decreased sensation into fingers. (RxD:32). Dr. Mirkin does not know if Petitioner told

Dr. Mirkin he cannot use his arm. (RxD:32). Dr. Mirkin claims he asked Petitioner about the dirty hands but did not record anywhere in his report whether there was a conversation about that issue. (RxD:33). Dr. Mirkin does not have a direct recollection of discussing that issue with him, only remembers Petitioner telling him he could not use his arm and he had callouses and grease which Dr. Mirkin does not find consistent. (RxD:33). Petitioner did tell Dr. Mirkin he had done some raking recently. (RxD:33). Dr. Mirkin did not ask Petitioner to explain what he meant by not being able to use his left arm where he reported raking just recently. (RxD:33).

Dr. Mirkin's Physical exam showed reduced cervical range of motion. (RxD:33). Petitioner describes pain radiating down his shoulder on range of motion of the neck. (RxD:35). That finding can be explained by cervical pathology. (RxD:35). He agrees the described mechanism of injury can cause or aggravate a cervical condition. (RxD:35). Dr. Mirkin believes Petitioner's physical exam was normal except for the reduced cervical range of motion. (RxD:38).

On review of the MRI images, he agrees there is degenerative disc disease and a slight bulge at C6-7 on the left and agrees that both radiologists identified the same pathology at the C6-7 level. (RxD:39-40). He further acknowledged that Dr. Wilkey identified pathology at the C6-7 level. (RxD:40). Dr. Mirkin acknowledges the MRI was static and this only shows the disc in one position, while an MRI taken in a different position might show more foraminal abnormality than a static MRI. (RxD:42). He agrees that compression of the nerve root can be associated with positional changes. (RxD:43). Dr. Mirkin did not review any treatment records after the September 10, 2014 note written by Dr. Wilkey's nurse, so he did not have the benefit of reviewing the treating physician records over the past year. (RxD:43). He is unable to comment on anything other than what he saw in his own examination. (RxD:44). He agrees that conservative treatment can temporarily alleviate symptoms from cervical pathology. (RxD:46). Where there is a C6-7 herniated disc on the left side there would be numbness and tingling in the ring and small finger, decreased reflex, possibly in the triceps. (RxD:46).

Rodney McQuaid testified on behalf of Respondent. (T.48). He is a manager, having worked for Respondent for 10 years. (T.49). He was a manager on the date of Petitioner's accident on June 1, 2014. (T.49). Petitioner did not report an accident to him and there were other managers working that day. (T.50). To the best of his knowledge, Petitioner did not report an accident to the other manager, Frank. (T.50). He believes Frank would have said something to him. (T.50). There is a procedure for reporting an injury to a manager or the owner. (T.51). On the date of the accident there were five or six employees out on the front line. (T.52). Nobody reported an accident to him on that date. (T.52). To the best of his knowledge, Petitioner did not call in on the days following the accident. (T.52). Up to June 1, 2014 Petitioner was performing his usual job duties, there were no problems with the quality of work performed by Petitioner and there were no complaints of any injuries prior to June 1, 2014. (T.55). Petitioner did not have good attendance prior to June 1, 2014. (T.54).

Francis Henke, the owner of Respondent, testified as well. (T.57). He has known Petitioner for at least 10 years. (T.57). Petitioner is a dismantler and he is a loader driver also. (T.58). The witness was not working on the date of the accident. (T.58). To the best of his knowledge, Petitioner did not report an accident that day. (T.58). The procedure is to tell a manager and the manager is required to report it to the owner. (T.58). The witness first found out about the claim when he received the lawsuit sometime in late June. (T.59). The date of first report of injury was about June 20, 2014. (T.59). There is no procedure for writing down when an employee calls into work. (T.59). The next time he saw Petitioner was when he came in to get his check, probably

Thursday of that week. (T.60). He told Petitioner he was fired because he missed too much time, and had missed 17 days from January 1st to June 1st. (T.61). He claimed that Petitioner pulled down his pants to show him he was laying in gravel and that is how hard he works, laying in the gravel and the witness told him he was still fired. (T61). He denies that Petitioner mentioned anything about a work accident on that day. (T.61). The witness denies that Petitioner mentioned anything about a work accident to him between June 1, 2014 and June 4, 2014. (T.61). He testified that employees are supposed to wear a hard hat but he is not very strict about it. (T.62). The manager, Frank did not report to him that Petitioner reported an accident. (T.63). Before the date of accident, Petitioner was performing his usual job duties. He was not having any problems or complaints with the quality of his work. (T.65). He did not complain of any injuries prior to that time period. (T.65).

Petitioner continues to have problems sleeping at night, with symptoms like his arm falling asleep and two fingers being numb. (T.22-23). He denies any prior neck or left arm problems, was always able to climb up and out of the tractor, carry transmissions, help carry motors. (T.23). Prior to this work accident he had no problems performing his work duties. (T.23).

He can use his left arm to grab things, and carry things, but nothing too strenuous. He rates his pain at a 7 (out of 10), and describes throbbing like something is stabbing through his shoulder. (T.44-45). He has trouble moving his neck to the left but not to the right. (T.45). He has trouble with daily activities, lifting his arm and uses the right arm mostly. (T.46).

CONCLUSIONS

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

The Arbitrator found Petitioner to be a credible witness. Petitioner's job duties require him to duck under the vehicles and racks he works beneath. Petitioner's history of injury provided to multiple medical providers detailing that he struck his head while performing his job duties is consistent with Petitioner's testimony. Further, the mechanism of injury is consistent with the nature of the injury and the objective pathology. In addition, Petitioner's testimony regarding the development and evolving nature of his cervical pathology following June 1, 2014 is corroborated by the testimony of Dr. Wilkey.

Petitioner testified, without rebuttal, that when he began walking away from the rack on which he had struck his head, Frank, one of the managers was walking toward him. Frank noticed the blood coming from Petitioner's head and asked if he needed medical care and whether he wanted to file paperwork. Petitioner credibly testified that he did not think it was serious enough to warrant immediate medical attention or completing any paperwork. Frank did not testify at trial.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner satisfied his burden of establishing that he sustained an accident that arose out of and in the course of Petitioner's employment by Respondent.

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

There is little dispute among the medical experts regarding the causal relationship of Petitioner's current condition of ill-being to the accident. Petitioner had no symptoms prior to the accident. Petitioner reported developing symptoms of neck and left-sided radiculopathy shortly following the work accident.

The opinion of Dr. Mirkin confirms the described mechanism of injury to be consistent with the nature of Petitioner's cervical pathology. Although Dr. Mirkin finds Petitioner's reported symptoms greater than he would expect given the objective findings, he does recommend further work up for the cervical injury, including a new MRI and nerve conduction studies. The Arbitrator finds the testimony and opinions of Dr. Wilkey more persuasive than those of Dr. Mirkin.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has satisfied his burden of establishing that his current condition of ill-being is causally related to the accident.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?
Issue (K): Is Petitioner entitled to any prospective medical care?

Dr. Wilkey testified Petitioner's treatment to date has been reasonable and necessary. This is the only opinion of record on this issue and it is credible where Dr. Wilkey reviewed the medical treatment records and he oversaw the majority of the treatment.

Dr. Wilkey has had the opportunity to see and evaluate Petitioner on numerous occasions and is in a better position to evaluate Petitioner's potential treatment course. He relies on both subjective and objective findings over the course of numerous evaluations. Dr. Mirkin testified to the need for additional testing and workup consisting of a new MRI and nerve conduction testing. But Dr.Mirkin's opinion recommending additional testing was made without the benefit of reviewing the most recent year of medical records. During that period Dr. Wilkey has noted significant developing symptoms such as triceps weakness. Accordingly, Dr. Mirkin's opinion regarding the need for surgery is not fully informed and carries less weight. As indicated above, the Arbitrator finds the testimony and opinions of Dr. Wilkey more persuasive than those of Dr. Mirkin.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner's medical care up to the date of hearing has been reasonable and necessary in light of the injuries sustained in the accident. The Arbitrator further finds Petitioner is entitled to the prospective medical care recommended by Dr. Wilkey.

Respondent shall pay reasonable and necessary medical services of $15,891.29, as set forth in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall further authorize and pay for the medical treatment recommended by Dr. Keith Wilkey, as provided in Sections 8(a) and 8.2 of the Act.

Issue (L): What temporary benefits are in dispute?
Issue (N): Is Respondent due any credit?

Petitioner has remained off work pursuant to the instructions of his treating physicians since his date of accident. Based upon the foregoing and the record taken as a whole, including the Arbitrator's findings with regard to issues C & F, Respondent shall pay Petitioner temporary total disability benefits of $378.05/week for

78-4/7 weeks, commencing 6/1/14 through 12/2/15, as provided in Section 8(b) of the Act. Respondent shall be given a credit of $2,400.00 for temporary total disability benefits that have been paid.

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

Mark Massey,
Petitioner,
vs.

NO: 14WC 30027

Terminix,
Respondent.

17IWCC0487

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed July 19, 2016, is hereby affirmed and adopted.

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

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

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $15,500.00. 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 4 - 2017
MJB/bm
o-7/25/17
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

MASSEY, MARK
Employee/Petitioner

Case# **14WC030027**

TERMINIX
Employer/Respondent

17IWCC0487

On 7/19/2016, 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 0.43% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICE
PATTI GIAMBATTISTA
PO BOX 99
E ALTON, IL 62024

0445 RODDY LAW PC
RICHARD ZENZ
303 W MADISON ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK MASSEY
Employee/Petitioner

v.

TERMINIX
Employer/Respondent

Case # 14 WC 30027

Consolidated cases: _____

17IWCC0487

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **April 19, 2016**. 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 _____

17IWCC0487

FINDINGS

On **May 13, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

Petitioner's condition of ill-being *was* causally related to the accident, but ***as of January 21, 2015 is no longer*** causally related to the accident.

In the year preceding the injury, Petitioner earned **$48,721.40**; the average weekly wage was **$936.95**.

On the date of accident, Petitioner was **55** 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 **$22,743.72** for TTD, **$N/A** for TPD, **$N/A** for maintenance, and **$N/A** for other benefits, for a total credit of **$22,743.72**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of **$624.63 per week for 37 weeks**, commencing **May 14, 2014 through January 27, 2015**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $22,743.72 for temporary total disability benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability benefits of **$562.17 per week for 25 weeks**, because the injuries sustained caused the **5% loss of the person as a whole**, as provided in Section 8(d)2 of the Act.

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

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

Signature of Arbitrator

July 14, 2016
Date

STATEMENT OF FACTS

The Arbitrator notes that the accident is stipulated. The Petitioner, a 57 year old male, testified that, to the best of his recollection, while working for Respondent as an exterminator on 5/13/14, he was squatting down under a deck when he stood up. The next thing he remembered was laying in the yard in water, because it had started raining. The inference was that he had struck his head on the decking above him. Notice of the accident is not disputed.

The Petitioner testified that he was unconscious for what appears to have been approximately 3 to 5 minutes. He finished his job, including 3 more stops, but testified he didn't recall them. When he went home, his fiancée, Penny Harbert, told him he should go to the hospital. Petitioner went to the Emergency Room at St. Francis Litchfield, was examined, underwent a CT scan of the head and was discharged home. The CT scan was negative. (Px6).

Petitioner followed up with Dr. Fulton's office where he saw Physician's Assistant, Sarah McFarland, who held the Petitioner off work through 5/30/14, and thereafter pending neurological evaluation. (Px6). The Petitioner also saw an optometrist for light sensitivity but no eye issues were reported. Petitioner was ultimately referred to neurologist Dr. Naseer for evaluation. (Px2).

Prior to seeing Dr. Naseer, Petitioner underwent a head MRI on 6/10/14, which was read as essentially normal. When he initially saw Dr. Naseer on 6/25/14, the Petitioner reported head pain, confusion, memory difficulties and nausea. These complaints essentially remained the same throughout the course of Dr. Naseer's treatment, other than no further complaints of nausea, but additional complaints of dizziness and personality changes. A 7/22/14 EEG was normal. Dr. Naseer diagnosed a concussion as well as post concussion syndrome. He treated Petitioner basically with medication, and held him off work through the last visit of 3/9/16. (Px2).

Dr. Naseer referred Petitioner to Dr. Gobel at the Vestibular Lab at Washington University. Petitioner's examination was unremarkable, with a questionable component of positional vertigo. Dr. Gobel advised that his head injury with possible light sensitivity and atmospheric pressure changes may be consistent with postconcussive migraine syndrome, and tenderness along the left nuchal line is sometimes seen in patients with occipital neuralgia. (Px5).

The deposition of Dr. Naseer was taken on 12/4/15. (Px4). He testified that the Petitioner's diagnosis was post concussion syndrome. In describing the condition, he testified that normal objective testing, such as head CT and MRI and EEG, was not unusual with such condition, and that the symptoms regarding headaches, memory and dizziness were common. The Petitioner also had an essentially normal neurological exam. Dr. Naseer also testified that when there is no such objective evidence of problems, it would be expected that there would be improvement over time. He testified: "the long-term effect is everything comes back normal, but they just do not feel back to normal." He testified that Petitioner had difficulty with coping with the injury and had a poor understanding of what was going on with his condition, and that a large part of his treatment of Petitioner, other than diagnostic testing and the vestibular referral, was reassurance that all the information was collected and that he was on the road to recovery. He noted that the Petitioner lacked confidence with regard to describing his condition, and would always look to Ms. Harbert before committing to an answer. (Px4). His behavior was abnormal in the office, and Dr. Naseer testified that at times the Petitioner appeared to be exaggerating his symptoms, and was "theatrical" (Px4; see pp. 16-18). He noted that there would be no way to prove or disprove complaints such as dizziness, lightheadedness and headaches in this case. He nevertheless believed that the Petitioner had not returned back to a normal state. (Px4).

Dr. Naseer testified that the main reason for holding the Petitioner off work was concern with regard to complaints of dizziness, and liability to both the Petitioner and his potential employer. For the same reason, he did not believe it was safe for the Petitioner to drive. Dr. Naseer believed that Petitioner will have difficulties adjusting to day to day life as well as difficulties carrying on day to day life activities at home. (Px4).

During his deposition, Dr. Naseer placed Petitioner at maximum medical improvement because enough time had passed since the trauma, he had obtained all the evaluations needed and there was no real improvement. On cross exam, with regard to work restrictions, Dr. Naseer indicated he didn't think the Petitioner should drive or do any kind of lifting or weight where he also has to move around due to dizziness. He noted that Petitioner's eye evaluations had not reflected any vision problems, and that his memory was generally intact. (Px4).

The Respondent had the Petitioner examined by neurologist Dr. Hogan on 9/3/14. (Rx1). Dr. Hogan initially indicated an essentially normal exam after a head injury with no scalp injury. The only thing significant about the examination to Dr. Hogan was elevated blood pressure. Petitioner's mini-mental status was within normal limits. The Petitioner reported to Dr. Hogan that he could not drive. Dr. Hogan opined that Dr. Naseer's treatment had been necessary and reasonable ("I would have to state that Dr. Naseer had little alternative but to treat the patient symptomatically as he has done."). However, he believed that the Petitioner could, and should, return to some form of light duty, as the longer he stayed off work, the more likely he wouldn't ever be able to return to full duty. (Rx1).

Dr. Hogan was then furnished with a number of surveillance videos of the Petitioner (Rx6). He noted the Petitioner demonstrated no imbalance in ambulation, and that the videos were in counter-distinction to his office visit. On that basis, the doctor felt that the Petitioner had reached MMI. He recommended temporary light duty restrictions, indicating this was pending neuropsychological evaluation, and that he thereafter should be able to return to full duty without limitation or restriction. (Rx2).

The Petitioner underwent a neuropsychological evaluation with Dr. Oliveri at Respondent's request. Dr. Oliveri found that the Petitioner presented for his evaluation with appropriate focused attention. He administered multiple neuropsychological tests, and indicated that the Petitioner exhibited multiple atypical validity factors that correlated with non-neurologic and non-psychiatric factors. The results were inconsistent with a valid representation of residual acquired brain-behavior dysfunction. Dr. Oliveri felt these results were more in keeping with non-injury-related factors contributing to his current complaints. In conclusion, Dr. Oliveri felt that the neuropsychological assessment results did not support residual acquired brain-behavior dysfunction. In light of the validity issues, his somatic/cognitive symptoms could not be taken at face value. Therefore, from a neuropsychological perspective, Dr. Oliveri felt there were no restrictions or limitations or need for additional treatment. (Rx4).

Following his review of Dr. Oliveri's report, Dr. Hogan issued a third report on 1/12/15. (Rx3). He noted that, based on his prior exam, review of the surveillance video and Dr. Oliveri's report, the Petitioner should return to light duty for 2 to 3 weeks, after which he could advance to regular duty, noting no evidence of neurological residual from the head injury. Dr. Hogan was asked to clarify this report, which he did on 1/21/15, noting that he did not believe the Petitioner was complying with making an effort to honestly and carefully answer Dr. Oliveri's questions during the neuropsychological evaluation. (Rx3).

The Petitioner has not returned to work since the accident and claims he often has insomnia. Dr. Naseer kept the Petitioner off work but ultimately released him to return to work with minor restrictions. At the present time, the Petitioner is trying to sell burial insurance for a few hours a day or a week, per his testimony.

The Petitioner testified that since he continues to have constant headaches at the top and into the back of his head. Initially, the headaches were severe, but they have since become less severe. Per his testimony and the medical evidence, the Petitioner alleges that he has little memory of May, June or July of 2014, after which his memory improved.

The Arbitrator notes that he reviewed the narrative summary of the Petitioner's circumstances and symptoms from May, 2014 through August, 2014 that was prepared by his fiancée, Ms. Harbert. (Px1). This narrative was admitted into evidence over the Respondent's objections. The Arbitrator also personally reviewed both the surveillance reports and videos submitted by Respondent. (Rx6). The reports and videos depicted the Petitioner on multiple occasions driving to and from stores and restaurants and medical visits. Interestingly, an 11/29/14 video depicted the Petitioner riding an ATV.

CONCLUSIONS OF LAW

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's condition of ill-being that resulted from the 5/13/14 accident was and remained causally related to that accident until 1/21/15, at which point the Arbitrator relies upon the report of Dr. Hogan in determining that causation ended at that point.

The Petitioner clearly was injured in the accident, which has been stipulated by Respondent. The question is what the result of that trauma is. The Petitioner complained about a variety of symptoms, including headaches, dizziness, memory problems, some degree of photophobia and vision problems and personality changes. The treating neurologist, Dr. Naseem, opined that the Petitioner's condition, post concussion syndrome, is causally related to the trauma. However, he also agreed that there was no objective evidence of a brain or neurological injury. He also agreed that the Petitioner's symptoms and condition essentially are determined based on his subjective complaints.

In reviewing the medical records and diagnostic testing, deposition of Dr. Naseem, as well as the reports of Dr. Hogan and Dr. Oliveri, the Petitioner's current condition can not be determined due to a significant level of exaggeration and, in Dr. Naseem's words, theatrical behavior. The Petitioner complained of dizziness, including initially with his condition actually falling down, and an inability to drive for any significant time period. The Arbitrator's determination is that there is a solid amount of evidence here which belies such problems. Dr. Naseem testified to a certain level of exaggeration, and the general need to rely on subjective complaints in a post-concussion situation with no objective evidence of injury. Dr. Hogan's initial report noted that on gait testing, Petitioner swung his arms in a theatrical manner. Dr. Oliveri noted that when Petitioner was ambulating in his office, he was prone to extend his arms to hold onto walls and tabletops to maintain his balance.

The surveillance reports and video presented by the Respondent covered multiple dates, and indicated, in the Arbitrator's view, no evidence of the things he complained of in terms of difficulty with driving and ambulating. Neuropsychological testing also indicated evidence of invalidity and what appeared to be purposeful behavior on his part to manipulate the test results.

The Arbitrator does believe that the Petitioner sustained a significant head trauma. The Arbitrator also believes that the Petitioner suffered some change in his normal condition at that time that has not returned to his pre-

accident state. At the same time, the Petitioner's own behavior prevents the Arbitrator from making any valid determination regarding his true level of function.

The Arbitrator relies upon the opinion of Dr. Hogan, including the evidence relied upon by Dr. Hogan per his report, in determining that the causal relationship of any ongoing post-concussion symptoms ended as of 1/21/15.

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

The parties have agreed, per Arbitrator's Exhibit 1, to the TTD period from 5/14/14 through 1/23/15. The disputed period is from 1/24/15 through 4/19/16, the date of hearing.

The Respondent paid TTD until after the Section 12 examinations with Drs. Hogan and Oliveri, through what appears to have been 1/27/15. The Arbitrator finds that the Petitioner is not entitled to further TTD benefits beyond that period based upon the medical records, the reports of Drs. Hogan and Oliveri and the surveillance video and reports. The Petitioner never testified to any type of significant job search or other attempts to go back to work other than trying to sell burial insurance. Moreover, the Arbitrator finds it significant that the Petitioner told Dr. Hogan that he was unable to drive, while the surveillance made it quite clear that the Petitioner was capable of and, in fact, did drive a motor vehicle on a regular basis. The Arbitrator is therefore not convinced that the Petitioner is unable to drive to get to a job, or to drive as part of a job.

The Arbitrator is under the assumption that the benefits were extended to 1/27/15, despite Dr. Hogan's last report being issued on 1/21/15, based on the time required to obtain the report and to present same to the Petitioner.

The Petitioner is entitled to TTD from 5/14/14 through 1/27/15.

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

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors;

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records. No

> single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor carries no weight in the determination of permanency.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as an exterminator at the time of the accident. While there is some evidence that the Petitioner may not be able to return to this job, the determination is very unclear given that there is evidence that the Petitioner exaggerated his level of disability, in particular his ability to drive. The fact that he is riding an ATV would seem very unusual for someone who complained of problems with dizziness and balance. As a result, a true determination of the Petitioner's abilities and disabilities is made very difficult. The Petitioner's prior job duties were not described with any detail, making it difficult to say how the Petitioner's occupation was impacted by this injury. The Arbitrator gives this factor some, but not significant, weight in the disability determination.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 55 years old at the time of the accident and 57 at the time of the hearing. No evidence was presented with regard to how the Petitioner's age might impact any permanent disability. As such, the Arbitrator gives this factor no significant weight.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner's earning capacity at present has been impacted significantly. That said, it is quite unclear whether it has been impacted by a true disability or solely by Petitioner's subjective complaints, which are called into question by the evidence presented in this case. This factor is given reasonable weight by the Arbitrator, but the weight given is both positive and negative for Petitioner's disability determination.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that, again due to issues regarding the Petitioner's credibility, it is hard to say how corroborative the records are.

Ultimately, the Arbitrator believes that the evidence, most significantly the surveillance and the neuropsychological testing of Dr. Oliveri, indicates that the Petitioner's subjective complaints have been exaggerated to some degree, perhaps significantly. That said, the Petitioner clearly sustained an accidental injury, which was corroborated by the initial medical indicating a goose egg on his head. The contemporaneous evidence certainly supports the fact that he hit his head and likely had a loss of consciousness.

That said, whether conscious or subconscious, the Arbitrator is convinced that the level of disability testified to and displayed to the treating physicians by the Petitioner is not credible. Something happened to this man as a result of the accident, though it appears to significantly be subjective and psychological. All objective evidence at this point does not support a significant injury, and the deposition of Dr. Naseer makes clear that he also questions the Petitioner's level of disability given his testimony regarding a level of exaggeration and theatrics.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 5% loss of use of the person as a whole pursuant to §8(d)(2) of the Act.

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

The Respondent is entitled to credit for previous TTD payments totaling $22,743.72.

STATE OF ILLINOIS)
)SS
COUNTY OF SANGAMON)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Gerald Hare,
Petitioner,

vs. NO. 09 WC 51335

17IWCC0488

Hein Construction,
Respondent.

DECISION AND OPINION ON §8(a) AND §19(h) PETITIONS

Timely Petitions pursuant to §8(a) and §19(h) of the Act having been filed by Petitioner and an oral motion for penalties at the time of the February 9, 2017 hearing made and due notice provided to all parties, the Commission, after considering the issues of causal relationship, a material change in Petitioner's condition, and penalties, and being advised of the facts and the law, denies Petitioner's Petitions pursuant to §8(a) and §19(h) of the Act and finds the issue of penalties waived.

Procedural History

This matter initially proceeded to hearing on November 3, 2010 before Arbitrator Jeffery Tobin. Issues presented at hearing were 1) causal relationship, 2) medical expenses, and 3) nature and extent of the injury. Arbitrator Tobin issued his decision on November 10, 2010 finding: 1) "Petitioner suffered from a ligamentous injury at C6 and an aggravation of a chronic fracture/congenital condition," 2) Awarding medical bills in the amount of $10,088.93 from Memorial Medical Center and Clinical Radiologists pursuant to §8(a) and §8.2 of the Act, and 3) Awarding permanent partial disability benefits pursuant to §8(d)2 of the Act to the extent of 7.5% loss use of the person as a whole. Arbitrator Tobin further found "Petitioner failed to establish that double crush syndrome or cubital syndrome was related to the work accident." Neither party reviewed the decision of the Arbitrator. As such pursuant to §19(b) of the Act, the decision was final as of December 10, 2010 and the decision of the Commission. Of note since neither party sought an appeal, no transcript of hearing was generated relating to the November 3, 2010 hearing.

Thereafter on February 18, 2011, Petitioner filed timely Petitions pursuant §8(a) and §19(h) of the Act. The matter proceeded to hearing on February 7, 2017 at which time Petitioner attempted to offer into evidence Petitioner's Exhibit 7, Petition for Penalties which was denied as untimely filed, but Petitioner was granted an opportunity to argue an award of penalties as an

17IWCC0488

issue. T. 6-7. The parties timely filed briefs, and oral arguments were heard on June 7, 2017. Petitioner raised no argument as to Penalties, and as such this issue is deemed waived.

FINDINGS OF FACT

A. Petitioner's Testimony

The Petitioner testified he sustained injury December 4, 2009 when he fell striking his neck on a wooden stake. T. 36-37. Petitioner testified prior to the injury, he did not experience any neck problems. T. 37. Petitioner testified he returned to work full duty as a cement finisher and experienced pain in his neck. T. 40. Petitioner testified regarding his complaints since his last hearing on November 3, 2010 stating: "It's all the same but it's getting worse and worse and worse." T. 41. Petitioner testified he experiences headaches since his injury. *Id.*

Petitioner testified to obtaining medical treatment in 2011 at the direction of Dr. Freitag including treatment at Memorial Medical Center. T. 42. Petitioner testified the treatment included physical therapy for his neck. T. 44.

Petitioner testified following the treatment he returned to work as a point man which required him to provide estimates. T. 46. Petitioner indicated such work was less physical, and he started a business providing bidding and estimates for concrete jobs. T. 47-48. Petitioner testified he hurts which requires him to take pain pills and muscle relaxers which he takes three to four times a day. T. 47; 49. Petitioner testified the pain is worse than what he experience in 2010. T. 50.

On cross-examination Petitioner testified he began taking Norco medication prior to his accident. T. 57-58. Petitioner testified following the hearing of November 3, 2010 he did not returned to work for Respondent but for another employer performing the same type of concrete work. T. 59. Petitioner testified he worked as a concrete finisher. T. 66.

Petitioner testified he sleeps on the floor and/or in a recliner. T. 72. Petitioner testified he began working as a supervisor approximately two years prior. T. 74. Petitioner testified Memorial therapy provided him with a neck stretcher which he uses one to three times a day. T. 77. Petitioner testified the neck stretcher was provided to him prior to the original arbitration hearing. T. 81.

B. Testimony of Jennifer Bridgewater

Ms. Jennifer Bridgewater was called to testify on behalf of Petitioner. Ms. Bridgewater testified she is employed by Memorial Medical Center as a decision support manager which sets charges for procedures. T. 14. Ms. Bridgewater identified Petitioner's Exhibit number four which she testified were bills related to treatment by Petitioner prior to April 4, 2016. T. 16. Ms. Bridgewater testified regarding a bill in the amount of $3,855.55 for a date of service of February 23, 2010 relating to MRI's. T. 18-19. Ms. Bridgewater testified regarding a bill in the amount of $3,175.00 for a date of service of August 9, 2011 relating to a nerve block. T. 19. Ms. Bridgewater testified regarding a bill in the amount of $3,077.00 for a date of service of July 13, 2011 relating to a nerve block. T. 20.

17IWCC0488

Thereafter the parties stipulated the bills in question were the proper amounts and reasonable and customary for the area with the only dispute being causal connection. T. 22-23. Respondent's attorney further indicated the bill for date of service of February 23, 2010 was not disputed as previously awarded on November 30, 2010 but remained outstanding as Respondent had failed to receive the proper documentation for processing of the bill. T. 21.

Ms. Bridgewater testified SIU was a different entity and not within her area. T. 27. Ms. Bridgewater testified she could not testify as to whether any bills were paid by Public Aid based on the information provided. T. 27. Ms. Bridgewater testified she had no knowledge as to who paid the bills. T. 31. Ms. Bridgewater testified the charges she identified were from Memorial Medical Center and the charges were reasonable and customary, but she did not know to what services they were related. T. 33.

C. Petitioner's Medical Treatment

Petitioner sought treatment on January 27, 2011 from SIU Healthcare- Orthopedic Surgery, Jacob Monsivais, PA complaining of chronic neck pain with a recent increase of symptoms over the recent months. Physical therapy was prescribed. PX1. Petitioner was re-evaluated on March 24, 2011 with continued complaints of pain and an MRI was recommended. An MRI was undertaken on March 28, 2011 which was compared to an MRI of December 8, 2009 showing no compressive disc herniations and no significant spinal canal or neural foraminal stenosis. PX1. Petitioner was re-evaluated on April 11, 2011 with continued complaints of neck pain, and an EMG was recommended. An EMG was performed on May 5, 2011 evidencing: 1) bilateral moderate radiculopathy at C6 and C7 as well mild C5 involvement; and 2) bilateral carpal tunnel syndrome, mild to moderate in right hand and mild in left hand. PX1. Petitioner was re-evaluated on July 25, 2011 at which time it was noted Petitioner underwent one injection with another being recommended and Petitioner to follow up thereafter. There are no further medical records regarding treatment with this provider.

On November 21, 2011 Dr. Per Frietag provided testimony *via* evidence deposition on behalf of Petitioner. Dr. Frietag testified he reviewed the treatment notes authored by Mr. Jacob Monsivais as well the March 28, 2011 MRI and the May 5, 2011 EMG and formulated a diagnosis of double crush syndrome. PX1, p.8. Dr. Frietag testified Petitioner was authorized off work as of January 27, 2011 and released to return to work as of May 20, 2011. PX1, P. 9-10. Dr. Frietag testified physical therapy as well as two injections was prescribed. Dr. Freitag explained such treatments helped relieve two components of the condition 1) mechanical (physical therapy) and 2) inflammation (injections). PX1, p. 11. Dr. Frietag testified Petitioner was placed at maximum medical improvement as of May 20, 2011 but would need periodic care due to his diagnosis of double crush syndrome. *Id.*

The records from Memorial Medical Center evidence Petitioner attended physical therapy from February 3, 2011 through May 5, 2011. PX5

On June 23, 2011 Dr. Salvacion examined Petitioner for a pain consultation. Petitioner complained of neck and bilateral upper extremity pain which bothered him since December

17IWCC0488

2009. Dr. Salvacion diagnosed cervical radiculopathy and cervical degenerative disc disease and recommended cervical steroid injections. PX5.

Dr. Salvacion performed the first injection on July 13, 2011 and the second injection on August 9, 2011. The first injection reportedly provided some relief with neck pain and headaches. PX5. On August 16, 2011 Petitioner's spouse telephoned advising Petitioner still complained of pain and did not wish to undergo any further injections. PX5.

On January 19, 2013 a cervical x-ray ordered by Jacob Monsivals PA evidencing no acute fracture; no prevertebral soft tissue swelling and osseous alignment is normal with no evidence of instability. On January 15, 2013 a cervical MRI was performed at the request of Dr. Frietag with comparison to the March 28, 2011 MRI evidencing no spinal canal or neural foraminal stenosis and no disc herniation. PX5.

D. Morris Marc Soriano, M.D.

Dr. Soriano prepared two reports based upon a review of Petitioner's medical records, March 7, 2010 and December 1, 2015. Dr. Soriano opined Petitioner did not suffer from double crush syndrome, and Petitioner's need for treatment in 2011 and thereafter was not related to the accident of December 4, 2009. RX2 & RX3. On June 21, 2012 Dr. Soriano provided testimony *via* evidence deposition on behalf of Respondent. RX4. Dr. Soriano testified Petitioner's current medical treatment was not related to the work injury. RX4, p. 7. Dr. Soriano testified Petitioner did not suffer from double crush syndrome as diagnosed by Dr. Frietag. RX, p.8. Dr. Soriano testified Petitioner did not suffer from radiculopathy, and Petitioner's chip fracture of C7 was not related to radiculopathy. RX4, p.17. Dr. Frietag further testified Petitioner's initial diagnoses of cervical spinous process fracture and inflammation of the ligaments was unrelated to Petitioner's current diagnosis of a bulging disc a C6-7 and double crush syndrome. RX4, p19.

CONCLUSIONS OF LAW

§8(a) Petition

"Under the provisions of section 8(a) of the Act, an employer is required to pay for all necessary medical, surgical, and hospital services that are reasonably required to cure or relieve the effects of an accidental injury sustained by an employee and arising out of and in the course of her employment. *820 ILCS 305/8(a)* (West 1998)." *Second Judicial District Elmhurst Memorial Hospital v. The Industrial Commission*, 323 Ill. App. 3d 758, 764 (2001). "[A]n employee is entitled to recover only those medical expenses which are reasonable and causally related to an industrial accident." *Zarley v. The Industrial Commission*, 84 Ill. 2d 380, 389 (1981).

Following the decision rendered on November 30, 2010, Petitioner re-initiated treatment at SIU Healthcare- Orthopedic Surgery on January 27, 2011 under the direction of Dr. Frietag. PX1. Dr. Frietag testified Petitioner suffers from double crush syndrome as a result of the December 4, 2009 accident which necessitated the treatment from January 27, 2011 through

May 11, 2011 as well as for the need of potential future treatment. Px1, p. 8-11.

Such treatment for double crush syndrome is not causally related to the accident of December 4, 2009 under "the law of the case" doctrine. "'[W]here an issue is once litigated and decided, that should be the end of the matter and the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit.' *McDonald's Corp. v. Vittorio Ricci Chicago, Inc.*, 125 Ill. App. 3d 1083, 1086-87, 81 Ill. Dec. 314, 466 N.E.2d 1116 (1984)." *Irizarry v. The Industrial Commission*, 337 Ill. App. 3d 598, 606 (2003). Placed at issue during the original hearing of November 3, 2010 was the issue of causal relationship. PX1 & RX 1. The Arbitrator specifically found as follows: "Petitioner failed to establish that double crush syndrome or cubital syndrome was related to the work accident." *Id.* Neither party appealed the decision of the Arbitrator, and as such, the decision became final and the decision of the Commission as of December 10, 2010. Any treatment undertaken by the Petitioner and bills incurred for such treatment as it relates to double crush syndrome is unrelated to the accident of December 4, 2009.

Moreover, Dr. Soriano opined Petitioner's need for treatment beginning in 2011 was unrelated to his accident of December 4, 2009 but due to a bulging disc at C6-7. RX4, p. 19. Such opinion is consistent with Dr. Salvacion's diagnosis of cervical degenerative disc disease. PX4. The Commission notes the cervical MRI performed on December 8, 2009 evidences a ligamentous injury at C6-C7 and "no evidence of a significant disc herniation or compromise of the spinal cord or spinal canal." PX4. The cervical MRI of March 28, 2011 as interpreted by Dr. Soriano evidences "left posterolateral broad-based disc protrusion without neuroforaminal or central stenosis at C6-7…it's a minimal degenerative change…" RX4, p. 11.

Based upon the above, the Commission finds Petitioner failed to prove his treatment commencing in January of 2011 is causally related to his accident of December 4, 2009. Therefore the Commission denies Petitioner's Petition pursuant to §8(a) of the Act.

§19(h) Petition

"The purpose of a proceeding under section 19(h) is to determine if a petitioner's disability has 'recurred, increased, diminished or ended' since the time of the original decision of the Industrial Commission. [citations omitted]. To warrant a change in benefits, the change in a petitioner's disability must be material. [citation omitted]." *Gay v. The Industrial Commission*, 178 Ill. App. 3d 129, 132 (1989).

The Commission finds Petitioner has failed to prove a material change in his condition as Petitioner has failed to prove a causal relationship between his current condition of ill-being (double crush syndrome or degenerative bulging disc at C6-7) and his accident of December 4, 2009. Moreover, in the decision of November 30, 2010 it is noted "Petitioner testified that after the accident he was not the same person anymore because he has pain in the back of his neck an sometimes he gets an electricity feeling between his neck and elbows." PX1 & RX1. At the hearing of February 9, 2017, Petitioner testified to pain in his neck and down his back and in his head. T. 40. Petitioner further testified he experienced the same pain as testified to in the original hearing but felt it was worsening. T. 41. The Commission finds such testimony does

17IWCC0488

not support a material change in Petitioner's disability. Therefore the Commission denies Petitioner's Petition pursuant to §19(h) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner's Petition pursuant to §8(a) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's Petition pursuant to §19(h) of the Act is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay the sum of $3,855.55, to the extent it is owing, for reasonable, necessary and related medical expenses under §8(a) of the Act, subject to the Medical Fee Schedule pursuant to §8.2 of the Act as awarded in the decision on November 30, 2010.

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $4,000.00. 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 7 - 2017
LEC/maw
o06/7/17
43

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Joshua D. Luskin

Charles J. DeVriendt

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

Dustin Roberts,
Petitioner,
vs.

NO: 14 WC 38467

City of Springfield,
Respondent,

17IWCC0489

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 18, 2016, is hereby affirmed and adopted.

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

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

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

DATED: AUG 8 - 2017
o080317
DLG/mw
045

David L. Gore

Deborah Simpson

Stephen Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROBERTS, DUSTIN
Employee/Petitioner

Case# **14WC038467**

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0489

On 11/18/2016, 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 0.62% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2934 BOSHARDY LAW OFFICE PC
JOHN V BOSHARDY
1610 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER O'BRIEN
DENNIS S O'BRIEN
620 E EDWARD ST
SPRINGFIELD, IL 62703

STATE OF ILLINOIS)
)
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
NATURE AND EXTENT ONLY

Dustin Roberts
Employee/Petitioner

v.

City of Springfield
Employer/Respondent

Case # **14** WC **38467**

Consolidated cases: _____

17IWCC0489

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 **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Springfield**, on **October 25, 2016**. By stipulation, the parties agree:

On **December 9, 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 $ **57,998.20**, and the average weekly wage was $ **1,115.35**.

At the time of injury, Petitioner was **42** years of age, ***married*** with **3** dependent children.

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

Respondent shall be given a credit of $7222.38 for TTD, $ for TPD, $ for maintenance, and $ for other benefits, for a total credit of $7222.38.

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 $ **669.21**/week for a further period of 63.25 weeks, as provided in Section **8(d)(2)** of the Act, because the injuries sustained caused 12.65 % loss of Person as a Whole.

Respondent shall pay Petitioner compensation that has accrued from **December 9, 2013** through **Ocotber 25, 2016** 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.

D. Dyan McCarty

Signature of arbitrator

11/10/2016
Date

ICArbDecN&E p.2

NOV 18 2016

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.

On December 9, 2013 Petitioner was employed as an Electrical Engineer II for the Respondent and was inspecting a roof on a newly constructed hotel. As Petitioner and the contractor were leaving the roof, which was white, Petitioner slipped on ice and landed on his right elbow, driving his arm up into his right shoulder. Petitoner felt immediate pain in the shoulder and notified his supervisor of the accident.

Respondent instructed Petitioner to go to the Orthopedic Center of Illinois for treatment. The day after the accident Petitioner was seen by Dr. Karolyn Senica, an orthopedic surgeon, with the Orthopedic Center of Illinois. (PX 2) Dr. Senica noted the work accident and examined Petitioner. Dr. Senica noted swelling at the shoulder, decreased range of motion, pain in the shoulder joint and an inability for Petitioner to hold up his arm. (PX 2) Dr. Senica's exam revealed positive impingement, drop arm and adduction crossover testing. (PX 2) Dr. Senica suspected a torn rotator cuff and ordered an MRI of the Petitioner's right shoulder.

An MRI of the right shoulder showed large joint effusion, fluid within the sub deltoid subacromial bursa, extending along the long head of the biceps tendon sheath. The MRI also revealed a full thickness tear with tendon retraction of the supraspinatus and infraspinatus tendon as well as a small tear of the glenoid labrum. (PX 2)

Dr. Karolyn Senica referred Petitioner to Dr. Christopher Maender of the same orthopedic group for further treatment. Dr. Maender diagnosed Petitioner with a large rotator cuff tear with biceps tendon retraction and recommended right shoulder arthroscopic rotator cuff repair and open biceps tenodesis. (PX 2)

On January 16, 2014 Dr. Maender attempted to perform an arthroscopic intra-articular debridement and rotator cuff repair and open biceps tenodesis. (PX 2) Dr. Maender noted in his operative report that during the arthroscopic portion of the exam Petitioner's findings were as noted on the MRI and, due to swelling, Dr. Maender felt it was best to proceed with an open repair of the rotator cuff tear as well as the biceps tendon. (PX 2)

Dr. Maender debrided the subscapularis tear down to bleeding bone and inserted a metal corkscrew anchor. (PX 2) Dr. Maender then turned his attention to the biceps tendon and noted it had withdrawn from the biceps tendon groove. Dr. Maender stitched the tendon, removed excess portions of the tendon, and secured it with a 6.25 mm SwiveLock. Dr. Maender also performed a subacromial bursectomy and decompression. Dr. Maender repaired the rotator cuff tear with three suture anchors evenly spaced across the tear. The sutures were attached to the SwiveLock. (PX 2)

Petitioner underwent therapy at Midwest Rehabilitation from May 7, 2014 through July 16, 2014. (PX 6) At his final physical therapy evaluation the therapist noted Petitioner demonstrated decreased strength, decreased range of motion in his shoulder and a burning pain on the top of his shoulder when he raised his arm. (PX 6) Petitioner felt he was 85% better.

Dr. Maender last saw the Petitioner on August 13, 2014. At that time he found a range of motion which was smooth and painless. The doctor noted it to be equal to that of the left shoulder. He further found excellent strength in all positions. He continued his earlier release to work full duty. (PX 2)

Petitioner notices that if he has to lift ceiling tiles with his right arm during the course of his work he will have pain and difficulty due to loss of strength.

Dustin Roberts vs. City of Springfield
IWCC No. 14 WC 38467

Under the amended Illinois Workers' Compensation Act the Arbitrator notes that the Commission shall base its Decision on five enumerated factors. All of the factors need not be present to award permanent partial disability.

(i) the reported level of impairment;

(ii) the occupation of the injured employee;

(iii) the age of the employee at the time of injury;

(i) the employee's future earning capacity;

(ii) Evidence of disability corroborated by medical records.

Therefore:

With regard to (i) of Section 8.1(b) of the Act:

Petitioner was examined by Dr. Lawrence Li for a Section 8.1(b) impairment rating and Section 12 exam on February 4, 2016. (RX 1, p. 6-7) Dr. Li examined the right and left shoulders and noted active flexion of 160 degrees and 170 degrees of passive flexion. On the uninjured left side active flexion was 180 degrees. (RX 1, p. 12) Active abduction on the right was 160 degrees and passive 170, which Dr. Li noted was slightly less than normal. (RX 1, p. 13) Active external rotation was 85 on the right and 90 degrees on the left and active internal rotation was to L4 on the right and L3 on the left, also slightly less than normal. (RX 1, p. 13) Dr. Li noted that Petitioner's muscle strength was slightly weaker on the right. (RX 1, p. 13)

Dr. Li used the diagnosis of rotator cuff tear to determine the impairment rating and arrived at a rating of 4 percent impairment of the right upper extremity and 2% of a body as a whole. (RX 1. P. 9, 15, 17) Dr. Li acknowledged that there is no latitude in rating impairment in that once the diagnosis is made there is a fairly narrow range of impairments. (RX 1, p. 17) Dr. Li acknowledged that there is a separate impairment class for labral tears and bicep tendon tears. (RX 1, p. 20) Dr. Li agreed the fact that Petitioner underwent an open repair of the biceps tendon and labrum is not reflected in the impairment rating. (RX 1, p. 23) Dr. Li agreed that an open repair is more invasive that an arthroscopic repair. (RX 1, p. 23)

The Arbitrator notes Dr. Li's testimony that the strict application of the 6th Edition Guides to the Evaluation of Permanent Impairment do not permit the combining together of multiple injuries or pathologies in the shoulder. For this reason the 6th Edition Guide does not present a complete assessment of the impairment to Petitioner's right arm and body. The Arbitrator gives moderate weight to this factor, particularly with Dr. Li's examination findings which are consistent with the Petitioner's testimony.

With regard to (ii) of Section 8.1(b) of the Act:

Petitioner resumed his employment for the Respondent in his previous position. As an electrical engineer he has to regularly reach above shoulder height and work in restricted spaces in order to perform his work inspecting properties. The Arbitrator gives this factor moderate weight.

With regard to (iii) of Section 8.1(b) of the Act:

The Petitioner was 42 years old at the time of injury. The Arbitrator notes that the Petitioner has remaining work life and the evidence indicates that some tasks required by his employment cause difficulty. The Arbitrator gives substantial weight to the age factor.

With regard to (iv) of Section 8.1(b) of the Act:

The Arbitrator concludes Petitioner's earning capacity has not been permanently impacted by his injury. The Arbitrator gives no weight to this factor.

With regard to (v) of Section 8.1(b) of the Act:

Petitioner notices that he continues to have a loss of strength when he performs activities with his arm away from his body or over his head. Petitioner continues to have a burning sensation in his shoulder. Petitioner notes that when he is active with his right arm he will have soreness and tenderness. The Petitioner demonstrated that he had lost about 10% decrease in adduction. Petitioner acknowledged that Dr. Maender was happy with his range of motion and strength at his last examination, with said measurements being referred to in the Arbitrator's findings of fact. The Arbitrator gives moderate weight to this factor.

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

Michael English,
Petitioner,

vs.

NO: 09WC 8565

Choate Mental Health Center,
Respondent,

17IWCC0490

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, 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 April 4, 2016 is hereby affirmed and adopted.

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

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

DATED: AUG 9 - 2017

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CJD/rlc
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Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ENGLISH, MICHAEL
Employee/Petitioner

Case# **09WC008565**

17IWCC0490

CHOATE MENTAL HEALTH CENTER
Employer/Respondent

On 4/4/2016, 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 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1167 WOMICK LAW FIRM CHTD
CASEY VANWINKLE
501 RUSHING DR
HERRIN, IL 62948

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

0558 ASSISTANT ATTORNEY GENERAL
KYLEE JORDAN
601 S UNIVERSITY AVE SUITE 102
CARBONDALE, IL 62901

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

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

APR 4 - 2016

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

17IWCC0490

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

Michael English
Employee/Petitioner

v.

Choate Mental Health Center
Employer/Respondent

Case # **09** WC **8565**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Herrin**, on **February 10, 2016**. 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 29, 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.

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

In the year preceding the injury, Petitioner earned **$59,568.00**; the average weekly wage was **$1,145.54**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

The parties stipulated at the time of arbitration that all temporary total disability benefits had been appropriately paid, and that Respondent was entitled to a credit for all temporary total disability benefits paid.

Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

The parties stipulated at the time of hearing that Respondent is liable for the unpaid medical bills submitted into evidence at the time of arbitration as Petitioner's Exhibit 10.

ORDER

The parties stipulated at the time of hearing that Respondent is liable for the unpaid medical bills submitted into evidence at the time of arbitration as Petitioner's Exhibit 10. Respondent is entitled to a credit for any bills paid under its group medical plan for which credit may be allowed under Section 8(j) of the Act.

Respondent shall pay Petitioner the sum of **$664.72/week** for a further period of **175 weeks**, as provided in **Section 8(d)2** of the Act, because the injuries sustained caused **35% loss of use of the person-as-a-whole.**

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

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

Melinda M. Price-Sullivan

Signature of Arbitrator

3/31/16

Date

APR 4 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael English
Employee/Petitioner

Case # 09 WC 8565

v.

Consolidated cases: N/A

Choate Mental Health Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on January 29, 2009, he was employed by Choate Mental Health in Anna, Illinois as a maintenance equipment operator and truck driver. He testified that his job was to drive what they called the food truck, and that he would go to one main kitchen, then load and haul the food out to different docks for different kitchens throughout the facility. He testified that his job was to drive the truck and the personnel in the back would bring the food out.

Petitioner testified that that on the day of the accident, they were done delivering and everything was secured in the back of the truck. He testified that he went to get into the truck and opened the door. He testified that there was snow and ice, and that when he opened the door his feet flew out from under him but he still had ahold of the door. He testified that he got his footing back and got into the truck. He testified that he noticed a "pull" in his back. He testified that he later he told his boss about it and eventually went to the doctor.

Petitioner testified that his doctor kept him off work for a few days and that he then went back on restrictions. He testified that it kept getting worse, so he went back to the doctor who ordered an MRI. He testified that he was then sent to Dr. Gocio who ordered a TENS unit in either March or April of 2009. He testified that Dr. Gocio placed him under work restrictions, and that he took them to his boss. He testified that he was then told to take them to Mike Moorman.

Petitioner testified that Dr. Gocio referred him to pain management with Dr. Newell. He testified that he did not have good results with pain management, and was eventually referred for a functional capacity evaluation in September of 2009. He testified that shortly after the functional capacity evaluation he was released from Dr. Gocio's care based on the results of the test. Petitioner confirmed that he was not recommended to undergo any type of surgical intervention.

Petitioner testified that the functional capacity evaluation led him to have restrictions of a lift limit of 15 pounds, but this was increased to 30 pounds based on Dr. Kennedy's recommendation. Petitioner agreed that his permanent restrictions include a 30-pound lift limit as well as limits of his bending, stooping, crouching and squatting. Petitioner testified that he presented Respondent with the restrictions, but they were unable to accommodate them. He testified that he went back to Mike Moorman and took the paperwork to him, and that Mr. Moorman said they had nothing for him, that he should go home and that he would hear from him. Petitioner denied hearing back from Mr. Moorman, and testified that he tried calling him but was told they still had nothing and that he would be in touch.

Petitioner testified that he was getting paid under workers' compensation and the occupational disability program through the State Retirement System. He testified that he did his own job search and tried to find work within his restrictions, and that he began searching in February 2010 and ended his search in October of 2010. He testified that the job contacts were unsuccessful in finding work within his restrictions.

Petitioner testified that he had to supply regular doctors' notes that said that he was still having issues and what his restrictions were, and that he supplied Respondent with a note every 30 days and then the retirement system every six months. Petitioner denied ever being contacted by anybody at Respondent addressing any possible work with the facility and that this went on for a number of years.

Petitioner testified that that he recalled going to an IME with Dr. David Kennedy, a spine specialist in St. Louis, in August of 2014. He testified that he understood that Dr. Kennedy felt like the work injury was the cause of what he was dealing with, and that the restrictions that were placed on him were an accurate and reasonable work restriction for his condition. He testified that Dr. Kennedy raised the weight lifting limit up to 30 pounds. He denied that anyone from Respondent ever contacted him about trying to find work within those restrictions.

Petitioner testified that he recalled meeting in February of 2015 with a vocational rehabilitation expert at his attorney's office, and that she was hired by the State of Illinois to talk to him about doing a transferrable skills analysis. He testified that he met with her for approximately one hour. He testified that he understood her report to indicate that based on his work history, restrictions, and age, he was unemployable in the current labor market.

Petitioner testified that that his back pain was "unreal" and that he was still on pain medication and a muscle relaxer. He testified that most of the time he is in pain, but he does not like taking pain medication because he wants to be able to do things. He testified that he has to go to the doctor each month because he takes narcotic pain medications.

Petitioner testified that in the summer of 2015 he received a letter from the State Retirement System notifying him that his occupational disability benefits were set to expire when he turned 65 in July of 2015. He testified that he was dependent on the disability benefits as a source of income. He testified that the only way he could maintain his benefits was to retire and begin drawing his pension, so he did so.

Petitioner testified that before he received the letter, he had no intention of retiring because he had a good job and was making good money. He testified that during the period of time that he was released from medical treatment but was placed under restrictions, he would have gone back to work if he could have found work or had been supplied with jobs within his restrictions by the State.

On cross-examination, Petitioner denied considering retiring at age 65 as long as his health was good. He testified that he and his wife built a new home, and they "had it all figured out" when things would be paid for. He testified that as long as his health continued, he wanted to go ahead and save for retirement. He testified that they built their home in 2001, and that he had not given a lot of thought as to when he would retire because they wanted a "nest egg."

On cross-examination, Petitioner agreed that he qualified for the "Rule of 85", and that he would have met his requirements for the "Rule of 85" approximately 2-3 years ago. He testified that he was eligible for retirement benefits and pension benefits, but during the six years he was not working he never considered retiring. Petitioner denied that he made more money in the combination of temporary total

disability benefits and occupational disability benefits, and testified that he made more money while working.

On cross-examination, Petitioner testified that he applied for Social Security Disability in July of 2010 because Respondent told him he needed to apply. Petitioner testified that his Social Security benefits were reduced each month due to his worker's compensation benefits. He testified that he began receiving Social Security benefits while he was doing his job searches.

On cross-examination, Petitioner testified that while applying for jobs, he was asked about his last employment. He testified that they typically asked for the reason for leaving, so he told them that he had gotten hurt at work. He testified that he told them that he had a back injury, and that it was a "red flag" and no one wanted to even talk. He testified that he told them that he had restrictions, and about half of the prospective employers would turn and walk away as soon as he said a back injury. Petitioner denied telling prospective employers that he was on Social Security Disability because he was looking for work.

On cross-examination, Petitioner testified that he was not sure exactly when he was granted Social Security Disability benefits. He agreed that Dr. Gocio gave him restrictions in the medium demand level, and that in October of 2010 he could work but only within those restrictions. When asked why he stopped searching for work after eight months, Petitioner responded that he had to take pain medicine and was told that he could not drive. He testified that it was unsafe for him to take pain medication and drive, so he would not do it. When asked if any doctor at that time actually stated that he could not work at all, Petitioner responded that he could not remember.

On cross-examination as to the job search logs, Petitioner testified that 99% of the time he went face-to-face but that he did call a couple of the prospective employers. He testified that he asked for openings, asked for applications and had a resume. He testified that he did not know what happened to the applications after they were filled out, but not every one of them wanted an application because they talked to him. He testified that when they found out the reason he was looking for other employment, it was the end of the conversation.

On cross-examination, Petitioner testified that he followed up with them when they told him they were not hiring to see if they were hiring at a later date. He agreed that he contacted multiple employers, like Teamsters 347, over and over again only days apart. Petitioner testified that he contacted Teamsters multiple times because he belonged to the union and he was told to stay in touch because they may have something that he could do.

On cross-examination, Petitioner agreed that when he called these places, he was trying to apply for jobs that he knew were within his restrictions. He denied thinking he could do construction jobs within his restrictions. He testified that he thought driving a truck was a good option, but that he was having trouble getting up and down off the truck so he could not do that either. He testified that he thought he could do pest control, but Terminex would not even talk to him. When asked if he thought he could be a security guard, Petitioner responded that nobody wanted to talk to him with a back injury at his age. He testified that at that time he was willing to try anything.

On cross-examination, Petitioner responded that he did not remember whether he ever filled out anything requesting from his employer reasonable accommodations under the Americans with Disabilities Act. He agreed that he picked up an alternative employment packet and submitted it to the facility. He further agreed that he had shoulder surgery in February of 2014 that was not related to his claim. He denied that his continued use of narcotics had anything to do with his shoulder or any other condition. He testified that he takes three Hydrocodone per day, but will try to skip one every once in a while. He testified that two different physicians told him that surgery was not an option.

On cross-examination, Petitioner agreed that after October 27, 2010 he did not apply for any additional jobs. He testified that he could not recall when he was approved for Social Security Disability, but agreed he had been receiving benefits for years. He testified that at the time of his accident, he was 58 years of age. He agreed that the SRS occupational disability benefits were different from the temporary total disability benefits he was receiving for his claim, he denied having received any benefits for his claim for four or five months prior to arbitration but he agreed that he had been receiving his pension benefits.

On cross-examination, Petitioner agreed that he had shoulder surgery after a fall and that he also had a second fall as well. He denied, however, that his back pain was increased during the course of the falls because he caught himself as he was going down.

On redirect examination, Petitioner testified that he thought he last received a temporary total disability check in October but did not receive any notification as to why it was being ended or suspended.

The Application For Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged that Petitioner slip and fell on ice on January 29, 2009. (AX2).

The medical records of Dr. Ravindranathan were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was referred to Dr. Gocio on March 6, 2009. (PX1).

Included within the medical records of Dr. Ravindranathan was an interpretive report for an MRI of the lumbar spine performed at Heartland Regional Medical Center on March 4, 2009. The report indicated that the impression was that of multilevel degenerative disease, most significant at L2-L3 and L5-S1. (PX1).

The records of Dr. Ravindranathan reflect that Petitioner was seen on January 30, 2009, at which time he was assessed with a back strain. Petitioner was seen on February 2, 2009, at which time it was noted Petitioner still had pain to the left lower back. Petitioner was next seen on February 16, 2009, at which time it was noted his back still hurt and he was referred to physical therapy. At the time of the February 9, 2009 visit, it was noted that Petitioner's back was slightly better but still hurt. At the time of the March 2, 2009 visit, it was noted that Petitioner still had pain in the lower back in the middle and had started going down the left leg. It was noted at that time that Petitioner may need a referral to neurosurgery. (PX1).

Included within the medical records of Dr. Ravindranathan was the Outpatient Initial Evaluation dated February 19, 2009. It was noted that Petitioner was referred to physical therapy with a chief complaint of low back pain on the left side radiating down to the upper third of the left thigh, as well as numbness to the upper thigh. It was noted that Petitioner had slipped on ice as he was trying to climb up the truck and was still holding on with his left arm on the handle. Petitioner stated that he did not fall, and that the pain did not start until the next day. It was further noted that Petitioner had undergone previous chiropractic treatment in the past. (PX1).

Included within the medical records of Dr. Ravindranathan was the emergency room visit note dated January 31, 2009 at Heartland Regional Medical Center. It was noted that Petitioner slipped and fell 3 times, and complained of left flank pain radiating to the front and left testicle. The injury was noted to have occurred in the patient's home, and the onset was four days prior. The Clinical Impression was noted

to be that of (1) fall; (2) acute lumbar strain. Petitioner was discharged home, and instructed to follow-up in two days. (PX1).

Also included within the medical records of Dr. Ravindranathan were various letters taking Petitioner off work for various timeframes. (PX1).

The medical records of Dr. Gocio were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect the Petitioner was assessed with (1) lumbar strain-unresponsive to standard treatment secondary to industrial injury; (2) lumbar degenerative disc disease. Petitioner was referred for an evaluation from Dr. Glennon for rehabilitation/pain for the lumbar strain; (2) an EMG of the right leg for questionable piriformis syndrome; (3) a TENS unit; (4) a follow-up visit in four weeks. (PX2).

The medical records of Herrin Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner underwent work hardening for a chief complaint of lumbar spondylosis and degenerative disc disease for the timeframe of August 20, 2009 through September 3, 2009. The records further reflect that Petitioner was recommended to undergo a Functional Capacity Evaluation on September 8, 2009. (PX3).

The physical therapy records of Herrin Hospital reflect that the progress note for the week of August 31, 2009 through September 4, 2009 noted that Petitioner had made slight improvement with material handling, but clinical inconsistencies were noted with ladder climbing. It was noted that Petitioner's current physical demand level was considered to be Light, while the required physical demand level was noted to be Medium. (PX3).

The records of Herrin Hospital reflect that Petitioner was seen at the Emergency Department on April 15, 2014 with a chief complaint of a fall. Petitioner presented with complaints of left side/flank pain, as well as difficulty urinating and nausea. The Past Medical History was noted to be positive for chronic back pain, posttraumatic stress disorder, depression, and gastroesophageal reflux disease. The records suggest that Petitioner was suspected to have kidney stones. The Discharge Summary noted that Petitioner fell at Home Depot two days ago. (PX3).

The records of Herrin Hospital reflect that Petitioner was seen at the Emergency Department on April 13, 2014 with a chief complaint of abdominal pain. It was noted that the pain started the night prior after a fall, and that Petitioner fell against his belly. Petitioner was diagnosed with acute pyelonephritis. Petitioner underwent x-rays of the lumbar spine on April 13, 2014, which were interpreted as revealing (1) no acute osseous abnormality of the lumbar spine; (2) degenerative changes; (3) dilated left renal collecting system. (PX3).

The records of Herrin Hospital reflect that Petitioner was seen in the Emergency Department on April 12, 2014, at which time he reported that he fell after tripping and that he fell forward landing on his right chest and hands. Petitioner had complaints of pain to the right rib, bilateral hands and bilateral shoulders. He was assessed with a fall with multiple contusions. The interpretive report for x-rays of the thoracic spine performed on April 12, 2014 suggested that there were no acute osseous abnormalities of the thoracic spine. (PX3).

The records of Herrin Hospital reflect that Petitioner was seen on July 17, 2012 with complaints of left eye visual changes. It was noted that Petitioner planned to undergo a left temporal artery biopsy. (PX3).

Included within the records of Herrin Hospital related to a fit-for-duty evaluation in August 2009 was a Position Description for Petitioner's position as a Maintenance Equipment Operator. Petitioner underwent a Functional Capacity Evaluation on September 21, 2009. The report noted that the overall test findings, in combination with clinical observations, suggested the presence of near full, though not entirely full, effort on Petitioner's behalf. The report further noted that the overall test findings, in combination with clinical observations, suggested considerable question be drawn as to the reliability/accuracy of Petitioner's subjective reports of reports of pain/limitation. It was noted that Petitioner tested within the "Light-Medium" physical demand level, and that Petitioner did not meet the physical requirements of his pre-injury job. It was noted that Petitioner had difficulty with low-level activities including bending/stooping and crouching/squatting, as well as material handling tasks. It was further noted that Petitioner also required frequent rest breaks, which consisted of sitting due to increased low back pain. (PX3).

The Functional Capacity Evaluation report noted that Petitioner presented with five of seven inappropriate (anatomically unreasonable) responses, suggestive of inappropriate illness behavior. The report noted that Petitioner perceived himself as meeting the physical requirements for less than sedentary strength work, according to Department of Labor standards. The report further noted that subsequent clinical testing indicated that Petitioner's subjective reports matched poorly with distraction-based objective findings. (PX3).

The records of Herrin Hospital reflect that Petitioner underwent physical therapy for the timeframe of July 28, 2009 through August 12, 2009, and that Petitioner also underwent physical therapy for the timeframe of June 5, 2009 through July 28, 2009 as well. (PX3).

The medical records of Heartland Regional Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent an MRI of the lumbar spine on March 4, 2009, which was interpreted as revealing multilevel degenerative disease, with findings most significant at L2-L3 and L5-S1. (PX4).

The records of Heartland Regional Medical Center reflect that Petitioner was seen in the Emergency Department on January 31, 2009. It was noted that Petitioner slipped and fell 3 times, and complained of left flank pain radiating to the front and left testicle. The injury was noted to have occurred in the patient's home, and the onset was four days prior. The Clinical Impression was noted to be that of (1) fall; (2) acute lumbar strain. Petitioner was discharged home, and instructed to follow-up in two days. (PX4).

Included within the records of Heartland Regional Medical Center were physical therapy notes for the timeframe of February 19, 2009 through March 6, 2009. (PX4).

The medical records of Graham Family Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner was seen on February 4, 2015 for swelling in his lip. Petitioner was assessed with allergic angioedema. Petitioner was seen on December 23, 2014 in follow-up for chronic low back pain. It was noted that the discomfort was most prominent in the lumbar spine, which radiated to the left posterior thigh. Petitioner characterized it as constant, moderate in intensity and sharp. It was noted that this was chronic, but an intermittent problem with an acute exacerbation. It was noted that Petitioner continued to have pain, but was able to get around okay. The assessment was that of chronic low back pain, and Petitioner was recommended to alternate using cold packs and moist heat, massage and home back strengthening exercises. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on September 26, 2014 at which time he presented with cold symptoms. Petitioner was assessed with an acute upper respiratory

infection. Petitioner was seen on September 24, 2014 for chronic low back pain. It was also noted that Petitioner had swelling in his lower lip on that date. Petitioner was assessed with chronic low back pain and allergic angioedema. Petitioner was seen on July 28, 2014, at which time he was seen for a recurrence of his allergic angioedema. Petitioner was also seen on June 25, 2014 for a transition of care from an inpatient hospitalization. It was noted that Petitioner had a lot of shoulder and abdominal trouble recently, but his back seemed to be stable. The records further reflect that Petitioner underwent a right shoulder arthrogram on June 19, 2014 for an indication of re-tear of the right rotator cuff. (PX5).

Included within the records of Graham Family Medicine was a Disability Medical Report dated July 16, 2014 completed by Dr. Graham. In the report, Dr. Graham indicated that Petitioner's diagnoses and concurrent conditions included multi-level disc disease of the lumbar spine, chronic back pain, use of medication with minimal relief and limited functional state. Dr. Graham indicated that Petitioner would not be able to return to work, would have lifetime limitations and would not be able to resume gainful employment. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on March 25, 2014 with complaints of low back pain. It was noted that he had been off the pain medications for one week and it had gotten worse. Petitioner was given a refill of Hydrocodone/Acetaminophen and Methocarbamol. Petitioner was seen on February 5, 2014 for a pre-operative history and physical for right shoulder surgery. Petitioner was also seen on July 17, 2012 to review his carotid Doppler. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on June 14, 2012 for chronic low back pain. It was noted that the pain was getting worse and that Petitioner would sometimes need to take four pain pills per day. Petitioner also presented with swelling in his lip on that date. Petitioner was given a prescription for Neurontin. Petitioner was seen on May 21, 2012 complaining of swelling in his bottom lip. The assessment was that of allergic angioedema. Petitioner was seen on May 14, 2012, at which time he presented with a sunburn as well as swelling in his lip. It was also noted at that time that Petitioner had chronic low back pain, which did not radiate. He was given a prescription for Neurontin. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on April 16, 2012, at which time he was seen for chronic low back pain. It was noted that Petitioner's TENS unit supplies had been stopped by the State. The assessment was that of chronic low back pain, for which Petitioner was given refills for his prescription pain medication. Petitioner was seen on April 2, 2012, at which time he presented with an earache. The assessment was that of allergic rhinitis due to pollen. Petitioner was also seen on January 17, 2012 for a medication refill. It was noted that Petitioner had some pain relief with narcotic pain medication. The assessment was that of chronic low back pain. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on December 8, 2011 for an evaluation for chronic back pain as well as a history of GERD. It was noted that Petitioner's discomfort was most prominent in the lumbar spine and did not radiate. It was noted to be a chronic problem, with essentially constant pain. Petitioner noted some pain relief with narcotic pain medication. Petitioner was seen on November 2, 2011, following a transition of care from Dr. Mohr. It was noted that Petitioner complained of chronic low back pain, which was most prominent in the lumbar spine and did not radiate. Petitioner also complained of generalized abdominal pain, located primarily in the periumbicular area. It was noted that Petitioner's pertinent surgical history included prior abdominal surgery. Petitioner was assessed with chronic low back pain and abdominal wall cellulitis. (PX5).

Included within the medical records of Graham Family Medicine were those from the Orthopaedic Institute of Southern Illinois pertaining to treatment rendered to Petitioner's right shoulder. Also included within the records of Graham Family Medicine was a Discharge Summary from Heartland

Regional Medical Center dated June 14, 2014 pertaining to a recent admission for a small bowel obstruction. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on January 13, 2014 with complaints of chronic low back pain. It was noted that Petitioner had some pain relief with narcotic pain medication and a TENS unit, and that he seemed to be doing fine. Petitioner was seen on November 21, 2013 with complaints of right shoulder pain, which initially started several weeks prior. It was noted that the apparent precipitating event was a fall, and that the mechanism of injury was compression. It was noted that Petitioner was recommended to undergo an MRI. Petitioner was also seen on November 5, 2013 for a follow-up from his shoulder x-ray. Petitioner was recommended to undergo physical therapy. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on October 31, 2013 with a diagnosis of allergic angioedema. Petitioner was seen on October 30, 2013 with complaints of abdominal pain. It was noted that there was some radiation to the back. Petitioner was recommended to undergo a stat CT for further evaluation. Petitioner was seen on October 28, 2013 with complaints of right shoulder pain. Petitioner was also seen on October 14, 2013 in regards to his mixed hyperlipidemia and chronic low back pain. He was recommended to do home back strengthening exercises. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on October 4, 2013 regarding his allergic angioedema. Petitioner was seen on July 15, 2013 for mixed hyperlipidemia, chronic low back pain and allergic angioedema. Pain medications were refilled at that time. Petitioner was seen on May 16, 2013 at which time he noted gross hematuria. Petitioner was also seen on May 7, 2013 for right foot pain. Petitioner was also seen on April 15, 2013 for gross hematuria, as well as chronic low back pain and mixed hyperlipidemia. Petitioner's pain medications were refilled at that time. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on February 4, 2013 for cold symptoms. Petitioner was seen on January 24, 2013 regarding his allergic angioedema. Petitioner was seen on January 15, 2013 for chronic low back pain, which was noted to be most prominent in the lumbar spine and did not radiate. Petitioner was given a refill for his prescription pain medications at that time. Petitioner was also seen on November 26, 2012 complaints of chronic low back pain. Prescription pain medications were refilled at that time. Petitioner was seen on November 14, 2012 regarding his allergic angioedema and left wrist pain. (PX5).

The records of Graham Family Medicine reflect that Petitioner was seen on September 13, 2012 regarding his chronic low back pain. Prescription pain medications were refilled at that time. The records reflect that Petitioner was seen on August 1, 2012 for chronic low back pain, at which time prescription pain medications were refilled. (PX5).

The Functional Capacity Evaluation dated September 21, 2009 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6.

The Petitioner's job search logs were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The Arbitrator notes that Petitioner applied on multiple occasions to various prospective employers, including Teamsters Union #347 and Womick Law Firm, among others, during the timeframe of February 11, 2010 through October 27, 2010. Multiple notations were also made regarding Petitioner's purported inability to be hired due to his back injury. (PX7).

The Transferable Skills Analysis prepared by Creative Case Management, Inc. dated February 21, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. (The Arbitrator notes that the Transferable Skills Analysis was also entered into evidence at the time of arbitration as

Respondent's Exhibit 6.) It was noted that it was the vocational case manager's opinion with a reasonable degree of vocational certainty that Petitioner was not employable in the open labor market, and that Petitioner was not a candidate for vocational rehabilitation services. (PX8).

The IME Report of Dr. David Kennedy dated August 19, 2014 was entered into evidence at the time of arbitration as Petitioner's Exhibit 9. (The Arbitrator notes that the same report was also entered into evidence at the time of arbitration as Respondent's Exhibit 5.) Dr. Kennedy noted that on January 29, 2009 Petitioner was in a loading area which was partially covered with ice, he slipped, and as he did so he tried to stop his fall by holding onto the door handle. It was noted that thereafter Petitioner began to have significant pain in the lower lumbar area and radiating pain into the left leg associated with the sensation of burning, pins and needles and difficulty with bending, twisting, stooping or sitting for more than a few minutes. Petitioner noted weakness of the legs which he described as causing multiple falls. The diagnostic impression was noted to be chronic lumbar pain. Dr. Kennedy noted that he believed Petitioner was able to work in a limited capacity based on the Functional Capacity Evaluation with no lifting greater than 30 pounds nor more than occasional bending, twisting or stooping. Dr. Kennedy indicated that Petitioner was at maximum medical improvement, and he did not think there was any active treatment that would increase his functional capabilities. (PX9).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The parties stipulated at the time of arbitration that Respondent was liable for unpaid medical bills. (AX1).

The SRS Occupational Disability letter dated June 5, 2015 was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. The letter noted that as of July 31, 2015 the occupational disability benefits will have been made for the maximum period of time allowed, and that under the provisions of the Retirement Systems Act, Petitioner was eligible to receive a pension at the time his occupational disability benefits ceased. (PX11).

The Summary of Disability was entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The Worker's Compensation Employee's Notice of Injury was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The form noted a date of injury or illness of January 29, 2009 at 1:15 PM. It was noted that the injury was not reported on the date of incident because there were no problems until the next day. It was noted that Petitioner started to get into his truck, his feet slipped on ice and he had to hold onto the door handle. The body part injured was that of the lower back. The form was completed on February 5, 2009 and was signed by Petitioner. (RX2).

The Supervisor's Report of Injury or Illness was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The report indicated that Petitioner called the office and told him that he had a doctor's appointment and said he had kidney problems. It was noted that Petitioner did not describe the body part injured during the course of the conversation that took place on January 30, 2009. The second page of the Report, however, noted that Petitioner complained of lower back pain, and that he was injured while stepping up into his truck and that he slipped on ice. (RX3).

The Demands of the Job dated February 26, 2009 was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration Petitioner sustained an accident on January 29, 2009 that arose out of and in the course of his employment with Respondent, that Respondent accepted and paid (or has agreed to pay) all reasonable and related medical benefits and that no further temporary total disability benefits beyond those already paid were in dispute at the time of arbitration. (AX1).

With respect to disputed issues (F) and (L), given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

Petitioner is alleging permanent and total disability. It is clear from the medical evidence that he is not permanently and totally disability from a medical standpoint, so the remaining option to consider is whether Petitioner sustained his burden of proof under the "odd-lot" theory.

The principles applicable to a finding of permanent and total disability are well settled. An employee is totally and permanently disabled when he is unable to make some contribution to industry sufficient to justify payment of wages to him. *A.M.T.C. of Illinois v. Industrial Comm'n, 77 Ill. 2d 482, 487, 397 N.E.2d 804, 34 Ill. Dec. 132 (1979).* Our supreme court has stressed, however, that the employee need not be reduced to total physical incapacity before a permanent total disability award may be granted. *Ceco Corp. v. Industrial Comm'n, 95 Ill. 2d 278, 286-87, 447 N.E.2d 842, 69 Ill. Dec. 407 (1983).* Rather, the employee must show that he is unable to perform services except those that are so limited in quantity, dependability, or quality that there is no reasonably stable market for them. *Alano v. Industrial Comm'n, 282 Ill. App. 3d 531, 534, 668 N.E.2d 21, 217 Ill. Dec. 836 (1996).*

If the employee'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, he may qualify for "odd-lot" status. *Valley Mould & Iron Co. v. Industrial Comm'n, 84 Ill. 2d 538, 546-47, 419 N.E.2d 1159, 50 Ill. Dec. 710 (1981).* An odd-lot employee is one who, though not altogether incapacitated to work, is so handicapped that he will not be employed regularly in any well-known branch of the labor market. *Valley Mould, 84 Ill. 2d at 547.* 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. *Alano*, 282 Ill.App.3d at 534-35, 217 Ill.Dec. 836, 668 N.E.2d 21.

The Arbitrator finds that that Petitioner has failed to meet his burden of proving that he falls into the "odd-lot" category in the case at hand. The Arbitrator notes that Petitioner's job search log for the timeframe of February 11, 2010 through October 27, 2010 (a total of 37 weeks in length) does not indicate whether Petitioner ever submitted a single job application or resume to any of the prospective employers. The Arbitrator notes that Petitioner testified that he asked for openings, asked for applications and had a resume, but he also admitted that not every one of them wanted an application because they talked to him. The Arbitrator further notes that Petitioner did not submit his resume into evidence. Given the lack of specificity on the job logs as contained in Petitioner's Exhibit 7, the Arbitrator is necessarily forced to speculate about the specific positions for which Petitioner was purportedly applying.

Furthermore, the Arbitrator notes that it appears that Petitioner discussed his back injury, his age and/or his ongoing workers' compensation claim with many of the prospective employers while

undergoing his self-directed job search. The Arbitrator notes that while Petitioner testified that he stopped performing job searches because his doctor restricted him from driving, there is no evidence in the medical records in this case to support such an assertion. That said, the Arbitrator finds that the type and quality of contacts in Petitioner's job search is sorely lacking and does not reflect a diligent but unsuccessful job search.

Furthermore, the Arbitrator notes that Petitioner agreed on cross-examination that he contacted multiple employers, such as Teamsters, over and over again mere days apart. Petitioner testified that he contacted Teamsters multiple times because he belonged to the union and was told to stay in touch because they may have something that he could do, yet he also testified that he thought driving a truck was a good option but then went on to indicate that he was having trouble getting up and down off the truck so he could not do that either. Frankly, the Arbitrator is admittedly confused as to when Petitioner would have been getting up and down off a truck after his restrictions were imposed given his testimony at the time of arbitration that he had not worked since 2009. That said, the Arbitrator finds Petitioner's testimony to be inconsistent and gives such testimony very little weight, particularly when coupled with his purported attempts to secure employment within his restrictions with his attorney's office on three different occasions. (PX7).

Additionally, the Arbitrator places very little weight on the transferrable skills analysis performed by Jana Range, CRC, LCPC on February 21, 2015 given the fact that nearly 4½ years had passed since Petitioner abandoned his purported self-directed job search and the transferrable skills analysis was performed, which noted that Petitioner had been out of the workforce since 2009. Similarly, the Arbitrator places little weight on the opinions of Petitioner's primary care physician, Dr. Graham, who indicated on July 16, 2014 that Petitioner would not be able to return to work, would have lifetime limitations and would not be able to resume gainful employment. The Arbitrator notes that no foundation whatsoever was laid for his opinions on this issue and therefore places little weight on such opinion. In light of the foregoing, the Arbitrator finds that Petitioner has also failed to prove 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.

As the Arbitrator finds that Petitioner has failed to meet his burden of proving that he falls in the "odd-lot" category, the Arbitrator finds that based on the record in its entirety, Petitioner sustained permanent partial disability to the extent of 35% loss of use of the person-as-a-whole as provided in Section 8(d)2 of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Torrie Ashby,

Petitioner,

vs. NO: 16WC 3652

17IWCC0491

Hy-Vee,

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, 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 December 5, 2016, is hereby affirmed and adopted.

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

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

17IWCC0491

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 11 2017
o072517
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ASHBY, TORRIE
Employee/Petitioner

Case# **16WC003652**

HY-VEE
Employer/Respondent

17IWCC0491

On 12/5/2016, 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 0.61% 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:

0149 LAW OFFICES OF WARREN DANZ
710 N E JEFFERSON ST
PEORIA, IL 61603

0358 QUINN JOHNSTON ET AL
CHRISTOPHER S CRAWFORD
227 N E JEFFERSON ST
PEORIA, IL 61602

17IWCC0491

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Torrie Ashby
Employee/Petitioner

v.

Hy-Vee
Employer/Respondent

Case # 16 WC 03652

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on October 20, 2016. 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 25, 2016, Respondent was operating under and subject to the provisions of the Act.

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

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

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 $10,556.00; the average weekly wage was $203.00.

On the date of accident, Petitioner was 37 years of age, single with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Based upon the Arbitrator's Conclusions of Law attached hereto, claim for compensation is denied.

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

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

William R. Gallagher

William R. Gallagher, Arbitrator

November 29, 2016

Date

DEC 5 - 2016

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained an accidental injury arising out of and in the course of his employment for Respondent on January 25, 2016. According to the Application, Petitioner "fell down stairs" and sustained an injury to the "head, back and neck" (Arbitrator's Exhibit 2). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner worked for Respondent as a dishwasher and, on January 25, 2016, Petitioner was scheduled to work second shift which began at 4:00 PM. Petitioner arrived at Respondent's store at approximately 3:30 PM and entered through the front door. Petitioner testified that he proceeded to walk up a flight of stairs to the right of the front door so that he could clock in. At trial, photographs of the stairs were tendered into evidence which revealed a flight of stairs with a landing at the top of them and a shorter flight of stairs to the left of the landing (Petitioner's Exhibit 6).

Petitioner testified that the stairs were not used by the public and the upstairs included a break room for employees, lockers, the area where he had to clock in, etc. Petitioner stated that the weather on January 25, 2016, was rainy and that he was wearing boots. Petitioner proceeded to walk up the flight of stairs, reached the landing, turned and attempted to walk up the second set of stairs to the left. At that point, Petitioner slipped and fell backward onto the landing.

On cross-examination, Petitioner agreed that when he was walking up the stairs, he was taking two steps at a time. In regard to the boots he was wearing, Petitioner acknowledged that Respondent did not require him to wear them. Petitioner also stated that there was a "club room" located on the second floor, but he did not know if the general public had access to it or not.

Six witnesses testified on behalf of Respondent when this case was tried. Five of the six witnesses' testimony was in regard to the circumstances of the fall Petitioner sustained. The testimony of the sixth witness was in regard to an offer light duty work and was made to Petitioner after he was released to return to work.

Stephanie Hascall testified on behalf of Respondent. Hascall was the Respondent's Health Market Manager. Hascall stated that the stairs where Petitioner sustained the fall are, in fact, used by the public and that the "club room" is rented out to customers for parties, events, etc. Further, she stated that the room was also used for cooking demonstrations for Respondent's customers. Hascall also observed Petitioner after he fell and noted that there was no accumulation of water on the stairs and that they were dry. She also stated there was carpeting at the base of the stairs and its purpose was to catch water that might be on the soles of shoes. The stairs themselves also had a rubber coating, another safety precaution. Finally, Hascall specifically remembered Petitioner climbing the stairs two at a time.

Josh Schreiner testified on behalf of Respondent at trial. Schreiner was Respondent's Assistant Manager. He observed Petitioner lying on the landing shortly after the occurrence. He stated that the stairs were dry and Petitioner was wearing boots that were untied.

Richard Allen testified on behalf of Respondent at the time of trial. Allen was Respondent's Food Service Manager. Allen also observed Petitioner on the landing shortly after the occurrence. He also noted that the stairs were dry and Petitioner's boots were untied. He also observed that some of the rubber was coming off of Petitioner's boots. Allen stated that the "club room" is rented to customers for meetings, parties, etc. and is also used for cooking demonstrations. Allen also testified that there were restrooms in the same area which were open for use by the general public.

Amanda Baumann testified on behalf of Respondent at trial. Baughmann was Respondent's Assistant Manager. She also observed Petitioner after he fell and confirmed that he was wearing boots with untied laces and the staircase was dry. She also said that the "club room" was used by customers for various purposes.

Chris Price testified on behalf of Respondent at trial. Price was the Store Director. Price also observed Petitioner after the accident and noted that Petitioner was wearing boots that were untied and the stairs were dry. He also said that the stairs were used by customers to access the "club room" and restrooms.

Following the accident, Petitioner was seen in the ER of St. Francis Medical Center. At that time, Petitioner gave a history of falling down stairs and that he had headaches, neck and back pain. Petitioner was diagnosed with a concussion and discharged (Petitioner's Exhibit 3).

Petitioner was subsequently seen and treated by Dr. Daniel Hoffman, a general practitioner, who initially saw Petitioner on February 1, 2016. Dr. Hoffman diagnosed Petitioner with a closed head injury, cervical strain and thoracic lumbar strain. He authorized Petitioner to be off work and ordered physical therapy (Petitioner's Exhibit 2).

Petitioner continued to be treated by Dr. Hoffman for neck and back pain as well as occipital headaches. Dr. Hoffman later referred Petitioner to Sally Coyle, an Advanced Practice Nurse, for evaluation of his headaches (Petitioner's Exhibit 2).

APN Coyle saw Petitioner on May 31, 2016. Coyle evaluated Petitioner and opined that it was difficult to determine the exact nature of his headache symptoms. Among other things, she recommended Petitioner make some changes in regard to his use of medications (Respondent's Exhibit 5).

Dr. Hoffman released Petitioner to return to work with restrictions of no bending, stooping or lifting more than 20 pounds. This release was effective on July 8, 2016 (Petitioner's Exhibit 2).

Jennifer Neice testified on behalf of Respondent when this case was tried. Neice was Respondent's HR Manager and she testified that she arranged for light duty to be offered to Petitioner when he was released to return to work. Petitioner did return to work for Respondent; however, Petitioner only worked a couple of days. According to Neice, Petitioner quit his job because it was not worth his time.

At trial, Petitioner testified that he has continued to experience severe headaches and stiffness in his neck, back and shoulders. In regard to his brief return to work for Respondent, Petitioner stated that the number of hours of work offered to him were so limited that he did not believe it was worth his time to continue to work there.

Conclusions of Law

In regard to disputed issue (C) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that Petitioner did not sustain an accidental injury arising out of and in the course of his employment for Respondent on January 25, 2016.

In support of this conclusion the Arbitrator notes the following:

There was no dispute that Petitioner fell down some stairs and sustained an injury as a result thereof on January 25, 2016.

Petitioner testified that the stairs were not used by the public and the upstairs contained a break room for employees, lockers, the area where he had to clock in, etc. Petitioner was aware of the fact there was also a "club room" but he had no knowledge whether it was used by the public or not.

Five of the six witnesses that testified on behalf of Respondent were either present at the time of the accident or shortly thereafter. Five of the witnesses stated that the stairs were used by the public and the "club room" was rented out to customers for parties, events, etc. Some of Respondent's witnesses also testified that the "club room" was used for cooking demonstrations.

The aforementioned witnesses also testified that the stairs where Petitioner sustained the fall were dry on the day of the accident. Stephanie Hascall also stated that the stairs had a rubber coating. The Arbitrator also noted the presence of that coating on the photographs of the stairs that were tendered into evidence.

While the evidence clearly indicates that the stairs were available for use by the public, this is not the critical issue in this case.

For Petitioner to prove that this accident arose out of and in the course of his employment for Respondent, he must prove that his employment exposed him to a greater degree of risk than the general public. Caterpillar Tractor Co. v. Industrial Commission, 541 N.E.2d 665 (Ill. 1989).

When Petitioner was climbing the stairs, he was performing an activity of daily life also performed by members of the general public. Petitioner's employment by Respondent did not expose him to a greater degree of risk than that of the general public. The stairs were dry and had a protective rubber coating.

Petitioner's actions in this case were similar to an employee sustaining an injury while walking across the floor at his employer's place of business. This was likewise held not to expose an employee to a risk greater than that faced by the general public. Illinois Consolidated Telephone Co. v. Industrial Commission, 732 N.E.2d 49 (Ill. App. 5th Dist. 2000).

In regard to disputed issues (E), (F), (J), (K) and (L) the Arbitrator makes no conclusions of law as these issues are rendered moot because of the Arbitrator's conclusion of law in disputed issue (C).

William R. Gallagher, Arbitrator

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

Jeffrey Grote,
Petitioner,

vs.

NO: 11WC 27800

Granite City Police Department,
Respondent.

17IWCC0492

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, medical, law of the case 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, 2016, is hereby affirmed and adopted.

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

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

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

DATED: AUG 11 2017
o072517
KWL/jrc
042

Kevin W. Lamborn

Michael J. Brennan

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GROTE, JEFFREY
Employee/Petitioner

Case# **11WC027800**

GRANITE CITY POLICE DEPARTMENT
Employer/Respondent

17IWCC0492

On 11/10/2016, 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 0.53% 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:

0895 MORMINO VELLOFF EDMONDS SNIDER
SAMUEL MORMINO
3517 COLLEGE AVE
ALTON, IL 62002

0299 KEEFE & DePAULI PC
JAMES K KEEFE JR
#2 EXECUTIVE DR
FAIRVIEW HTS, IL 62208

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

Jeffrey Grote
Employee/Petitioner

v.

Granite City Police Department
Employer/Respondent

Case # 11 WC 27800

Consolidated cases: N/A

17IWCC0492

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **September 30, 2016**. 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 **Law of the Case**

FINDINGS

On **April 28, 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 *in the cervical spine is not* causally related to the accident, but the current condition of ill-being *in the left elbow and left shoulder are* causally related to the accident.

In the year preceding the injury, per the stipulation of the parties, Petitioner earned **$66,454.44**, and the average weekly wage was that of **$1,277.97**.

On the date of accident, Petitioner was **40** years of age, ***single*** with **2** dependent children.

Respondent is entitled to a credit of **$ALL AMOUNTS PAID** for medical bills paid through its group medical plan under Section 8(j) of the Act.

Respondent paid $0 in TTD, $0 in TPD, $0 in maintenance, $0 in non-occupational indemnity disability benefits, and **$17,446.66** in other benefits (*i.e.*, permanent partial disability), for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner the sum of **$669.64/week** for a further period of **37.95 weeks**, as provided in Section 8(e) of the Act, because the injuries caused **15% loss of use of the left arm.**

Respondent shall be given a credit of **$17,446.66** in other benefits (*i.e.*, permanent partial disability), for which credit may be allowed under Section 8(j) 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.

Melinda M. Pace-Sullivan

Signature of Arbitrator

11/8/16

Date

ICArbDec p. 2

NOV 10 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Jeffrey Grote
Employee/Petitioner

Case # 11 WC 27800

v.

Consolidated cases: N/A

Granite City Police Department
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

The parties stipulated at the time of hearing that on April 28, 2011, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent. (AX1).

Petitioner testified that on that date, he was asked to investigate a situation involving an elderly individual who had not contacted family members for a few days. He testified that when he got to the individual's residence, he was able to gain access through an unlocked window in the carport. He testified that in order to get through the window, his partner cupped his hands and helped boost him through. He testified that when he entered, he entered face first with his arms stretched out. He testified that he had to lower himself down, and that as his partner was "shimmying" him through the window, he extended his arms out in front to hold him up. He testified that most of his weight was on his left arm, and that when his left arm hit the floor, it slid out in front of him and he heard a pop. He testified that his chest and neck areas hit the floor, and that his head was turned to the left.

Petitioner testified that since he had less than three feet of space, he had to pull his legs in and "ball up." He testified that with his face turned to the left his neck was extended, and that once he pulled his legs in, he had to roll over and tuck his head in order to get onto his right to get up. He testified that when he was crawling through window, his adrenaline was rushing as he did not know if there was a dog or if someone was in the house with a gun. He testified that he felt sharp pain from his lower neck to the shoulder area, as well as down the arm.

Petitioner testified that he ultimately returned to police headquarters and reported the incident. He testified that he thought he did something to the arm, and that his hand was numb. He testified that he sought medical treatment at Dr. Eavenson's office, where he had treated in the past for a shoulder problem. He testified that he previously had a torn labrum in the left shoulder for which he treated with Dr. Eavenson and Dr. Paletta.

Petitioner testified that his first treatment following the accident was with Dr. Eavenson. He testified that he told him where his pain was located, and that he ordered an x-ray and an MRI and started chiropractic treatment. He testified that he saw Dr. Eavenson a couple of times, and that around May 4th he had an MRI of the cervical spine. He testified that before the MRI, he was sent for x-rays and an MRI of the left shoulder. He testified that he continued to treat with Dr. Eavenson until he was sent to Dr. Paletta. He testified that when he started treating with Dr. Paletta, he was having problems mainly of numbness to the hand, elbow and shoulder, and that he had occasional problems from his neck down to the shoulder.

Petitioner testified that he saw Dr. Gornet on August 15, 2011, and that when he first saw him, he was having occasional neck pain with occasional headaches and pain coming down his shoulder to the hand. He testified that the biggest problem that drove him to see Dr. Gornet was his hand being numb. He testified that Dr. Gornet began treating his neck, and that he had some injections and physical therapy but no long-term relief was provided. He testified that he ultimately had surgery on August 28, 2012, which was a disc replacement at C5-6. He testified that after surgery, the pain coming from his neck down his arm was relieved and that he noticed immediate results after surgery.

Petitioner testified that prior to undergoing surgery with Dr. Gornet, he had been on light duty and that he typically sat at the front desk, fed prisoners, took complaints that walked in and answered the phones. He testified that he was released to full duty in September of 2012, and that he has been working full duty since, responding to calls and doing the things that he used to do.

Petitioner testified that he is still having numbness and tingling in his pinky and ring fingers occasionally. He testified that before surgery, these fingers were numb all the time. He testified that the numbness and tingling in the ring and pinky fingers is activity-related, especially when he puts his arm up on the window. He testified that he can "flick" his elbow and feel something in his pinky. He testified that he no longer has constant burning and tingling like he did before the surgery performed by Dr. Gornet.

On cross examination, Petitioner testified that he is right-hand dominant. He agreed that he last saw Dr. Paletta on August 17, 2011, and that since he last saw Dr. Paletta, he has not gone back to anyone else for his left elbow. He further denied having seen anyone since August 17th for his left shoulder.

The *curriculum vitae* of Dr. Matthew Gornet was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Dr. Mark Eavenson were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records pertained to treatment rendered during the timeframe of April 28, 2011 (at which time the impression was that of a possible recurrent SLAP tear) through September 4, 2012 (at which time the "diagnostic code" was that of status post left shoulder arthroscopy, status post ulnar nerve transposition, cervical disc protrusion, cervical radiculiitis). (PX2).

The medical records of MRI Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The records reflect that Petitioner underwent a post-arthrogram MRI of the left shoulder on April 29, 2011, which was interpreted as revealing (1) small focal low grade partial thickness articular surface tear in the insertional fibers of the conjoined tendon of the posterior supraspinatus and anterior infraspinatus tendons; there are underlying enthesopathic cystic/edematous changes in the greater tuberosity; (2) post-surgical changes in the superior labrum compatible with prior SLAP repair; there is a tiny cleft of intraarticular contrast at the posterosuperior labral cartilaginous junction; this may relate to a tiny non-displaced labral tear; correlate with prior imaging and arthroscopic findings at the time of SLAP repair would be of benefit. The records further reflect that Petitioner also underwent an MRI of the cervical spine on May 4, 2011 and August 20, 2012 as well. (PX3).

The medical records of CT Partners of Chesterfield were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The records reflect that Petitioner underwent a left glenohumeral joint injection on May 11, 2011, a post-myelogram CT of the cervical spine on December 5, 2011, a CT of the cervical spine on August 20, 2012; a CT of the cervical spine on November 26, 2012; and a CT of the cervical spine on August 29, 2013. (PX4).

Copies of MRI films were entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The medical records of Dr. George Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on May 11, 2011, at which time it was noted that Petitioner had previously been under Dr. Paletta's care for a left shoulder problem and that in 2010 he had undergone arthroscopy and labral repair. It was noted that Petitioner had not been having problems related to the shoulder until April 28, 2011 when he was climbing in the window of the home of an elderly person. It was noted that Petitioner was complaining of persistent pain as well as numbness and tingling into the fourth and fifth fingers. The impression was that of (1) left shoulder sprain; (2) no evidence of recurrent rotator cuff tear or progression of the previously-noted partial thickness tear; (3) possible small recurrent superior labral tear. Petitioner was recommended to undergo an injection of the shoulder and a short course of physical therapy. As to the numbness and tingling, an EMG and nerve conduction studies was recommended to evaluate the ulnar nerve and to rule out any component of cervical radiculopathy. (PX6).

Included within Dr. Paletta's records was a Patient Consultation Visit for Dr. Phillips on May 11, 2011 pertaining to consultative electrical diagnostic studies. The impression was that of findings consistent with chronic ulnar neuropathy across the left elbow, and the study was not impressive for an additional cervical radiculopathy. The EMG and Nerve Conduction Study Review dated May 17, 2011 noted that, upon review of the May 11, 2011 study of Dr. Phillips, Dr. Paletta's impression was that of cubital tunnel syndrome with ulnar neuropathy, left elbow. It was noted that Petitioner was recommended to use a night splint, and that if it failed to reduce his symptoms, he may need to consider ulnar nerve transposition. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on June 17, 2011, at which time it was noted that he stated that the elbow was not any better and if anything it was worse, that he had a lot of difficulty with any pressure on the medial side of the elbow, that he complained of numbness and tingling in the ulnar nerve distribution and that he complained of continued medial elbow pain. The impression was that of (1) persistent symptomatic cubital tunnel syndrome, left elbow; (2) persistent complaints of left shoulder pain, status post arthroscopy. Petitioner was recommended to consider ulnar nerve transposition. It was noted that Dr. Paletta did not see any obvious evidence to explain the complaints of continued discomfort in the shoulder, and it was noted that Petitioner inquired about a repeat arthroscopy of the shoulder. It was noted that Dr. Paletta did not see any evidence of progression of the rotator cuff tear or any evidence of significant residual labral pathology. (PX6).

The records of Dr. Paletta reflect that Petitioner underwent (1) left elbow exam under anesthesia; (2) left elbow ulnar nerve transposition, subcutaneous type; (3) left shoulder exam under anesthesia; and (4) left shoulder diagnostic arthroscopy on June 23, 2011 for pre- and post-operative diagnoses of (1) cubital tunnel syndrome with ulnar neuropathy, left elbow; (2) recurrent left shoulder pain status post SLAP repair. (PX6).

The records of Dr. Paletta reflect that Petitioner was seen on July 15, 2011, it was noted that he was doing well and that he still had some complaints of numbness and tingling involving the lateral border of the hand and the fifth finger. It was noted that Dr. Paletta did not think that Petitioner required continued physical therapy for the shoulder, and that he thought his intermittent discomfort would likely resolve but there was no structural abnormality that would explain the complaints. Petitioner was recommended to undergo physical therapy for the elbow. At the time of the August 17, 2011 visit, it was noted that overall Petitioner was doing well and that he stated that the shoulder felt good. It was noted that Petitioner was undergoing an evaluation for the cervical spine as there may be some cervical issues contributing to some ongoing complaints. It was noted that Petitioner had an excellent outcome regarding the elbow, and that it may take upwards of a year before all of the tingling resolved. It was noted that Petitioner had full range of motion of the elbow and good strength, and that he did not require any additional therapy. It was noted that Petitioner did not require any restrictions to the shoulder or elbow,

and that he was at maximum medical improvement with regard to the shoulder and elbow with exception of the fact that it may take some time for the numbness to resolve completely. (PX6).

The medical records of Dr. Matthew Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The records reflect that Petitioner was seen for treatment of the cervical spine during the timeframe of August 15, 2011 through August 29, 2013. The Operative Report dated August 28, 2012 reflects that Petitioner underwent disc replacement at C5-6 for a pre- and post-operative diagnosis of cervical radiculopathy with discogenic neck pain. The records reflect that Petitioner was placed at maximum medical improvement on August 29, 2013. (PX7).

The transcript of the deposition of Dr. Gornet (dated February 9, 2012) was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. Given the date of the deposition transcript and the reference to Dr. Gornet's testimony in the prior 19(b) Arbitration Decision issued by Arbitrator Simpson, the Arbitrator infers that this particular testimony from Dr. Gornet was already considered as part of the 19(b) arbitration hearing that took place on April 18, 2012.[1] (PX8).

The medical records of West County Care Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The transcript of the deposition of Dr. Gornet (dated October 23, 2014) was entered into evidence at the time of arbitration as Petitioner's Exhibit 10. Dr. Gornet testified that he is an orthopedic surgeon whose practice is devoted to spine surgery. He testified that initially the focus was on the shoulder because it was thought that the shoulder might have been the cause of Petitioner's specific shoulder complaints, and that it was not an unusual situation. He testified that it was his understanding that Dr. Paletta did a diagnostic arthroscopy of Petitioner's left shoulder, and that there was no significant pathology discovered during the course of that procedure. (PX10).

Dr. Gornet testified that Petitioner ultimately underwent surgery, which consisted of a C5-6 disc replacement, and that he had an excellent clinical outcome. He testified that it was his recollection that the imaging showed changes which correlated to C5-6 into the foramen causing foraminal stenosis. He testified that intraoperatively, he saw a small foraminal herniation on the right and a larger one on the left, which were easily removed and then replaced with an artificial disc. He testified that surgery was performed on August 28, 2012, and that Petitioner's progress post-operatively was excellent. He testified that the purpose of the surgery was to cure and relieve the effects of Petitioner's work-related injury, which included shoulder pain, arm pain, neck pain and headaches. He testified that Petitioner's shoulder and arm symptoms that were present since the time of the accident were related to a cervical pathology, which subsequently when it was removed, his symptoms went away. (PX10).

Dr. Gornet testified that he last saw Petitioner on October 13, 2014, at which time his strength was normal, he was doing remarkably well and felt very well. He testified that Petitioner's prognosis was excellent. He testified that he did not believe that Petitioner had any significant residual, and that he was working full duty with no restrictions and was very pleased with his result. (PX10).

The transcript of the deposition of Dr. Paletta (dated March 5, 2015) was entered into evidence at the time of arbitration as Petitioner's Exhibit 11. Dr. Paletta testified that he is an orthopedic surgeon who was fellowship trained in sports medicine. (PX11).

Dr. Paletta testified that he previously treated Petitioner in 2010 for a tear of the labrum in the left shoulder, and that he last saw Petitioner on November 10, 2010 at which time he was discharged because

[1] In light of the prior review and consideration of the testimony by Arbitrator Simpson, no rulings on any objections raised during the course of the deposition were made in the margins of the transcript entered into evidence at the time of arbitration as Petitioner's Exhibit 8.

he had made a full recovery and was doing well. He testified that he next saw Petitioner on May 11, 2011 at the referral of Dr. Eavenson for complaints of left shoulder pain as well as some intermittent numbness and tingling into the left hand. He testified that as to the numbness and tingling in the hand, the possibilities he was considering were either cubital tunnel syndrome or cervical in origin. He testified that when he ordered the EMG, he thought it was possible that Petitioner's problem was at least in part caused by cervical radiculopathy, and that cervical radiculopathy can cause symptoms in the shoulder as well. (PX11).

Dr. Paletta testified that the nerve conduction studies showed that the numbness and tingling into the fourth and fifth digits appeared to be coming from the ulnar nerve at the level of the elbow, or cubital tunnel syndrome. He testified that the EMG ruled out electrophysiologic evidence to support that the numbness and tingling were coming from a cervical origin, but that there were always false positives and false negatives. He testified that given the results of the EMG, he came to the conclusion that Petitioner had persistently symptomatic cubital tunnel syndrome, that the numbness and tingling in the fourth and fifth fingers was from the elbow and that he had persistent complaints of left shoulder pain with the possibility of a recurrent tear of the labrum. (PX11).

Dr. Paletta testified that at the time of the June 17, 2011 visit, he recommended that Petitioner undergo an ulnar nerve transposition and that they consider potentially looking in the shoulder because, in the post-operative setting, it can be difficult even with an MR arthrogram to state definitively whether there was a recurrent tear. He testified that he believed that the accident of April 28, 2011 might have caused or contributed to cause Petitioner's cubital tunnel syndrome, and that the surgery was a direct result of the accident and was necessitated by that condition. He testified that on June 23rd, Petitioner underwent surgery. He testified that he basically did nothing in the shoulder at the time of surgery, and that there was no identifiable injury or pathology in the shoulder that would account for Petitioner's pain. Dr. Paletta testified that he believed that Petitioner's numbness and tingling were from cubital tunnel syndrome at the elbow, and that his shoulder pain certainly could have been from a cervical origin. (PX11).

On cross examination, Dr. Paletta agreed that when he saw Petitioner on August 17, 2011 at which time he reported that his left shoulder was doing good, he took it to mean that Petitioner was not having any problems with the left shoulder and testified that Petitioner's exam looked pretty good at that point. He agreed that Petitioner did not complain of left shoulder pain as of August 17th. He agreed that it was possible that his left shoulder pre-operatively was more related to a referred elbow issue than perhaps a cervical issue. (PX11)

The transcript of the deposition of Dr. Eavenson (dated July 31, 2015) was entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Dr. Eavenson testified that he is a chiropractor. He testified that he started treating Petitioner back in 2000 for low back pain, in 2007 for an ankle, in 2010 for a left shoulder surgery and most currently in April of 2011. He testified that in his review of the medical records in preparation for the deposition, he did not see any indication of Petitioner having suffered from any sort of cervical problems prior to this injury. (PX12).

Dr. Eavenson testified that he previously provided Petitioner treatment for a left shoulder injury that occurred in 2010 from a softball injury related to which he underwent surgery for a torn labrum with Dr. Paletta. He testified that he believed Petitioner's initial diagnosis was that of a recurrent SLAP tear, and that the focus of his attention and treatment as of the initial visit on April 28, 2011 was on the left shoulder. He testified that Petitioner's initial treatment was focused on the shoulder. (PX12).

Dr. Eavenson testified that as of May 3, 2011, he believed that the numbness and tingling in the left arm and hand involving the middle three fingers might or could have been related to his cervical condition. He testified that the treatment provided at his facility until Dr. Paletta completed Petitioner's

shoulder and elbow surgery was that of physical therapy to the neck and shoulder, which he believed were necessitated by the accident on April 28, 2011 because Petitioner had no other history. He testified that he left it to Dr. Paletta to determine if there was shoulder pathology. (PX12).

Dr. Eavenson testified that the types of complaints that Petitioner had following the shoulder and elbow surgery were that of ongoing neck pain, headaches and tingling in the arm. He testified that the shoulder surgery was diagnostic, and that the ulnar transposition surgery was primarily done to alleviate the numbness and tingling in his fourth and fifth fingers on the left hand. (PX12).

The bill of MRI Partners of Chesterfield was entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The bill of CT Partners of Chesterfield was entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The bill of MFG Spine, LLC was entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The bill of The Orthopedic Center of St. Louis was entered into evidence at the time of arbitration as Petitioner's Exhibit 16. The bill of St. Louis Spine & Orthopedic Surgery Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The bill of West County Care Center was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. The bill of Premier Anesthesia, LLC was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. The bill of Dr. Mark Eavenson was entered into evidence at the time of arbitration as Petitioner's Exhibit 20.

The transcript of the testimony of the 19(b) hearing was entered into evidence at the time of arbitration as Petitioner's Exhibit 21.

The Decision and Opinion on Review for 13 IWCC 649 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The Decision and Opinion on Review affirmed and adopted the 19(b) Arbitration Decision dated November 7, 2012, which held that Petitioner did not prove a compensable accident with respect to the current condition of the his cervical spine and therefore no benefits would be awarded with respect to the current condition of the cervical spine, and that Petitioner was not entitled to any prospective medical care as a result of the accident. (RX1).

The Request for Hearing from the 19(b) hearing held on April 18, 2012 was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

CONCLUSIONS OF LAW

The parties stipulated at the time of arbitration that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on April 28, 2011. (AX1).

With respect to disputed issues (O) pertaining to the law of the case and (F) pertaining to causation, given the commonality of facts and evidence relative to both issues, the Arbitrator addresses those jointly.

The Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being as it pertains to the cervical condition, including the cervical disc replacement surgery performed by Dr. Gornet, is causally related to the April 28, 2011 work accident. In support of this conclusion, the Arbitrator relies on the final decision of the previous 19(b) hearing, and finds that the Decision and Opinion on Review in 13 IWCC 0649 is the Law of the Case with respect to the issue of whether Petitioner's condition of ill-being in the cervical spine is causally related to the underlying accident.

The Law of the Case Doctrine provides that the unreversed decision of a question of law or fact made during the course of litigation settles that question for all subsequent stages of the suit. The principles underlying the Law of the Case Doctrine apply to matters resolved and proceedings before the Illinois Workers' Compensation Commission. *Irizarry v. Indus. Comm'n*, 337 Ill. App. 3d 598 (2nd Dist. 2003).

The Arbitrator notes that at the time of the April 18, 2012 19(b) hearing held before Arbitrator Simpson, Petitioner had been evaluated by Dr. Matthew Gornet who testified via deposition. Dr. Gornet opined that Petitioner suffered from a C5-6 disc herniation and that the disc herniation was causally connected to the work accident of April 28, 2011, for which he recommended surgery to correct the condition. At the time of the 19(b) hearing held on April 18, 2012, Petitioner requested that the Arbitrator (and thereafter the Commission when the 19(b) Arbitration Decision was appealed) order Respondent to approve the C5-6 disc replacement surgery as recommended by Dr. Gornet. (RX1). The Arbitrator notes that at the 19(b) hearing, Respondent submitted contrary evidence from Dr. Michael Chabot, who opined that the current cervical condition was unrelated to the work accident and that surgery for the cervical spine was neither reasonable nor necessary. (RX1). The Arbitrator further notes that the Request for Hearing form and review of issues clearly state that causal relationship for the cervical spine and the reasonableness and necessity of the treatment recommended by Dr. Gornet for the cervical spine were at issue at the time of the 19(b) hearing on April 18, 2012. (RX2)

The Decision and Opinion on Review in 13 IWCC 0649 affirmed and adopted the 19(b) Arbitration Decision, which found that the cervical condition and the need for the C5-6 disc replacement recommended by Dr. Gornet was neither reasonable, necessary nor causally related to the work accident of April 28, 2011. The Decision and Opinion on Review denied all prospective medical care for the April 28, 2011 work accident. As no appeal was taken by either party, the Decision and Opinion on Review thereafter became a final order.

While Petitioner now seeks a finding that the cervical condition and surgery performed by Dr. Gornet ***after*** the 19(b) hearing was reasonable, necessary and causally related to the work accident, the Arbitrator finds that these were the identical factual and legal issues raised at the prior 19(b) hearing and, as such, the Decision and Opinion on Review is final and the Law of the Case.

The Arbitrator further finds that the current condition of ill-being as it pertains to the left elbow and left shoulder are causally related to the accident of April 28, 2011.

With respect to disputed issue (J) pertaining to reasonable and necessary medical services, the Arbitrator finds that Petitioner's care and treatment for the cervical spine was not reasonable, necessary or causally related to his work accident of April 28, 2011. As a result thereof, no medical benefits are awarded for treatment rendered to the cervical spine beyond those as already awarded as part of the prior 19(b) hearing.

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injury, the Arbitrator notes that Petitioner's injuries occurred on April 28, 2011 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that Petitioner underwent a left ulnar nerve transposition, and that there was no pathology found at the time of the left shoulder arthroscopic surgery. Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the left arm under Section (e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERSON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

David Sloan,

Petitioner,

17IWCC0493

vs.

NO: 13 WC 7391

Premium Transportation/Earl Henderson Trucking,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of causal connection, medical expenses, prospective medical treatment, wages, 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 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 October 27, 2016 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.

17IWCC0493

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 11 2017
DLS/plv
o-7/13/17
46

David L. Gore

Stephen J. Mathis

DISSENT

I must respectfully dissent from the majority's decision affirming the Arbitrator's findings. I am not persuaded by the evidence presented that Petitioner's alleged cervical and thoracic conditions and the need for prospective treatment are causally related to his employment by Respondent. I find Petitioner's testimony not credible. At hearing, Petitioner testified that his neck pain started at the time of the accident. He further testified that he complained of neck and back pain in the emergency room and at his follow-up appointment at Salem Family Health Care the next day. However, the medical records contradict Petitioner's testimony. The records from the emergency room at St. Anthony's Hospital on the date of accident, December 20, 2012, show that Petitioner had no complaints with respect to his neck and the examining physician ruled out traumatic spinal injury. The emergency room CT scan of the neck purportedly showed a left-sided C5-6 protrusion and the examining physician interpreted it to be pre-existing. The follow-up records from Salem Family Health Center on December 21st and 28th and January 7th do not show any complaints of neck or back pain. Complaints of neck and upper back pain are not found in the records until January 23rd, where APN Mary Piper at Salem Family Health Care noted Petitioner "now complains of upper back, neck, and across shoulders pain."

Respondent's Section 12 examiner, Dr. Cantrell, reviewed all of Petitioner's medical records and noted the lack of documented symptoms in the neck and upper back proximate to the accident. Dr. Kovalsky did not review the emergency room records or the records of Salem Family Health Care. He testified that he "assumed" that Petitioner's neck pain started, at most, a few days after the accident, but he admitted that he never specifically asked Petitioner about the

timing of the onset of neck pain complaints. Dr. Kovalsky testified that normally neck pain would occur within a day or two of the accident. Petitioner told Dr. Kovalsky that all of his problems and complaints started with the accident. Dr. Kovalsky testified that the pathology at C5-6 was most likely preexisting and he did not know whether this disc level was responsible for any of Petitioner's symptoms. He further testified that it was possible that the small central disc herniation at C6-7 was preexisting, but he believed – based on Petitioner's history of immediate neck pain – that the accident caused or aggravated the C6-7 herniation. Furthermore, Dr. Kovalsky's notes explain that the surgery would be elective. His recommendation for a cervical fusion is based on Petitioner's complaints; Dr. Kovalsky states that there is no objective necessity for cervical surgery.

Dr. Smith testified that she would defer to Dr. Kovalsky's opinions with respect to Petitioner's cervical condition. Dr. Smith testified that Petitioner's thoracic spine MRI showed multilevel disc degeneration. She opined that the degeneration was likely pre-existing, but the mid-back pain Petitioner complained of was either directly or indirectly related to the accident. She opined that Petitioner's mid-back pain was the result of facet syndrome which could have been caused by the accident or developed secondary to Petitioner's low back pain. She explained that thoracic pain is often aggravated by cervical and lumbar pain. She testified that if Petitioner did not initially complain of mid-back pain that would not be unusual, if he was focused on areas of more severe pain. However, Dr. Smith relied on Petitioner's history that his mid-back pain started on the day of the accident along with his neck and low back pain.

In conclusion, I would find that the evidence presented does not corroborate Petitioner's testimony and fails to show a credible medical causal connection between Petitioner's alleged cervical and thoracic conditions of ill-being and the need for the thoracic rhizotomy and cervical fusion. Based on the above, I must respectfully dissent from the decision of the majority.

Deborah L. Simpson

Deborah L. Simpson

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

17IWCC0493

SLOAN, DAVID L
Employee/Petitioner

Case# **13WC007391**

EARL L HENDERSON TRUCKING
Employer/Respondent

On 10/27/2016, 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 0.47% 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:

0144 CRAIN MILLER & WERNSMAN LTD
BRIAN C WERNSMAN
623 E BROADWAY PO BOX 867
CENTRALIA, IL 62801

1739 STONE & JOHNSON CHTD
J MURRAY PINKSTON
111 W WASHINGTON ST SUITE 1800
CHICAGO, IL 60602

17IWCC0493

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)

David L. Sloan
Employee/Petitioner

v.

Earl L. Henderson Trucking
Employer/Respondent

Case # **13** WC **7391**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **July 14, 2016**. 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 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 **$42,728.73**; the average weekly wage was **$872.01**.

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

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

Respondent shall be given a credit of **$48,666.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$48,668.46**

ORDER

Respondent shall authorize the treatment recommended by Drs. Kovalsky and Smith, including, but not limited to, the recommended cervical spine surgery (including the precedent pre-operative MRI of the cervical spine) and the thoracic spine rhizotomy.

Respondent shall pay the reasonable and necessary medical services in the amount of **$64,025.63** (*i.e.*, as included in Petitioner's Exhibits 3, 7, 9, 11, 14 and 17) as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to Petitioner. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent is entitled to a credit for all benefits paid under its group health plan under Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of **$581.34/week** for **185 4/7** weeks, **for the timeframe of December 20, 2012 through July 14, 2016,** as provided in Section 8(b) of the Act.

Respondent shall be given a credit of **$48,666.46** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$48,668.46**

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.

Melinda M. Rowe Gallivan

Signature of Arbitrator

10/25/16

Date

ICArbDec19(b)

OCT 27 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

David L. Sloan
Employee/Petitioner

Case # 13 WC 7391

v.

Consolidated cases: N/A

Earl L. Henderson Trucking
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that on December 20, 2012, he had been employed as a truck driver for Respondent for just over five years and that his duties were that of a dedicated driver to North American Lighting. He testified that he moved freight from plant to plant and swapped out trailers, unloaded trailers and did whatever needed to be done. He testified that on December 20, 2012, he was driving south on Dietrich Blacktop and had just gotten the truck into 10th gear (which would have been approximately 55 MPH) when a gust of wind blew his tractor-trailer over. He testified that the driver's side of the truck landed and slid on the pavement, and that he was transported from the scene by ambulance to St. Anthony's Hospital in Effingham.

Petitioner testified that he has numbness and tingling in his left hand, as well as pain in the hand and problems with grip strength. He testified that he still has a similar pain in his low back and mid back as he did on his last visit to Dr. Smith in February of 2015, and he described spasms in the mid back radiating down the left side. He testified that he has not returned to see Dr. Smith because she told him that until the treatment was approved, there was no other reason for her to see him. He also testified that he still has pain in his neck, cannot sit or stand for long periods of time and does not believe that he could load or unload trailers.

Petitioner testified that prior to the date of accident, he had no prior symptoms or problems with his neck, mid back, low back, SI joint, left shoulder, left arm or left hand. He testified that he has had no intervening accidents or traumatic injuries to any of those body parts since the accident at issue.

The *curriculum vitae* of Dr. Aiping Smith was entered into evidence at the time of arbitration as Petitioner's Exhibit 1.

The medical records of Dr. Aiping Smith were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. At the time of the February 12, 2013 visit, the chief complaint was noted to be that of right equals left low back pain at the beltline radiating into Petitioner's left posterolateral thigh and leg with numbness and tingling in the left foot in a non-specific distribution. The impression was that of low back pain, probable lumbar strain. Petitioner was recommended to see a pain specialist for possible cortisone injections or, alternatively, more physical therapy. It was noted that there was no surgical intervention that Dr. Steinke would recommend. Petitioner was instructed to return on an as needed basis if his symptoms changed or worsened. It was noted that from a structural standpoint Dr. Steinke could

not see anything that would keep Petitioner from working, but because of his pain Petitioner was not able to drive for any length of time. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on March 13, 2013, at which time it was noted that Petitioner had low back pain since the accident of December 20, 2012 when the semi he was driving blew over, but that his back pain seemed to be improving now. It was noted that the back pain was primarily on the left side of the low back but over the last 1-2 weeks, it seemed to be improving quite a bit and that he previously had numbness and weakness in the left lower extremity but this also seemed to be improving. It was noted that Petitioner had had physical therapy which he felt worsened the pain, but that he did have some good response to the SI joint manipulations. The impression was that of (1) minimal degenerative disc disease of the lumbar spine; (2) left sacroiliac joint pain; (3) low back pain; (4) tobacco use. It was noted that Petitioner was to return on an as needed basis. At the time of the July 25, 2013 visit, it was noted that Petitioner's symptoms had been worsening for the past month. The impression was that of (1) left-sided low back pain extending to the left posterior thigh; essentially normal lumbar spine MRI except for mild facet degenerative joint disease multilevel; the pain could be due to SI joint dysfunction, cannot not completely rule out facet syndrome; (2) history of neck pain with C5-6 disc protrusion; (3) history of GERD; (4) left upper extremity injury during the accident. Petitioner was recommended to have an SI belt fitting and was instructed to continue his home exercise program; it was also noted that he may benefit from left SI joint injections, the first of which was performed on August 26, 2013 and the second of which was performed on September 10, 2013. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on September 26, 2013, at which time he reported 60% improvement after the SI joint injection. It was noted that there was significant leakage of the contrast dye inferiorly suggestive of the disruption of the SI joint capsule. It was noted that Petitioner was currently seeing Dr. Kovalsky for neck pain with disk herniation at C5-6. The impression was that of (1) left-sided low back pain, most likely due to the left SI joint dysfunction with two strong positive diagnostic SI joint injections; there is also evidence of SI joint capsule disruption on the left; (2) history of neck pain with C5-6 disk herniation; (3) history of GERD, unable to tolerate Mobic; (4) left upper extremity injury status post-surgical treatment at outside facility. It was noted that Petitioner may benefit from a left SI joint rhizotomy. It was noted that Petitioner was currently off work because of neck pain per Dr. Kovalsky's recommendation. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on March 25, 2014, at which time he underwent a left SI joint injection. It was noted that Dr. Kovalsky requested the injection and also mentioned possible SI joint fusion in the future if Petitioner's pain did not respond to the SI joint injection as well as the physical therapy, and that Dr. Kovalsky wanted to follow up after Petitioner's left shoulder pathology had been addressed. At the time of the April 4, 2014 visit, Petitioner was seen in follow-up for left-sided low back pain after left SI joint injection. It was noted that Petitioner had reported 50% pain improvement after the injection performed on March 25, 2014 that lasted for a couple of days, after which he felt a big "pop" in the left side of his lower back. The impression was that of (1) left-sided low back pain extending to the left posterior thigh with popping in and popping out of the back, and that Petitioner was suggesting his pain was still from the left SI joint and possible unstable SI joint; (2) history of neck pain with C5-6 disc herniation; (3) shoulder pain currently treated by Dr. Ahn; (4) history of GERD, unable to tolerate Mobic; (5) previous MRI of poor quality but reported only very early disc dessication and disc degeneration at T12-L1 which could not explain Petitioner's current pain in the left SI joint area. Petitioner was recommended to have physical therapy done at the Centralia Center to see if the SI joint could be stabilized. It was noted that Petitioner may be a good candidate for SI joint rhizotomy, but that Dr. Kovalsky planned for him to have a SI joint fusion after his shoulder pain and wrist pain had been addressed. It was also noted that Petitioner was currently off work per Dr. Kovalsky's recommendation and that Dr. Smith would not change that. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on May 8, 2014 for follow-up left sided low back pain. It was noted that Petitioner had had some physical therapy at Centralia, and felt a 50% improvement of the pain after the therapy. It was noted that Petitioner reported that after the therapist adjusted his left SI joint it appeared to be stabilized for about 2 weeks, but yesterday while he was busy working on his high lumbar muscle spasm, the left SI joint appeared to pop out. It was noted that Dr. Kovalsky had recommended to do the non-surgical treatment for the left SI joint pain while Petitioner was working with Dr. Ahn for the left shoulder, and that left shoulder surgery was pending. The impression was that of (1) current left-sided low back pain, appears to be due to SI joint dysfunction with some instability; (2) three positive left diagnostic SI joint injections; (3) history of neck pain with C5-6 disk herniation; (4) left shoulder pain, currently following with Dr. Ahn; (5) history of GERD, unable to tolerate Mobic; (6) previous MRI of poor quality, reported very early disk dessication and disk degeneration at T12-L1. It was noted that approval was to be sought for SI joint rhizotomy. It was also noted that Petitioner was currently on light duty per Dr. Ahn's recommendation, and that Petitioner had been off work since his work place could not accommodate light duty. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on May 27, 2014, at which time Petitioner underwent radiofrequency ablation of left L5 dorsal rami, S1, S2 and S3 lateral branches under fluoroscopic guidance. At the time of the July 3, 2014 visit, Petitioner was seen for left-sided buttock pain. It was noted that Petitioner reported 3-4 weeks of 50% improvement after the rhizotomy, and that he noticed pain in the left buttock, mainly a cramping pain. It was noted that overall Petitioner thought he had 50% improvement in back pain, and that he was scheduled to have left shoulder surgery by Dr. Ahn which was postponed due to needing to rule out Lyme disease. The impression was that of (1) overall 50% improvement of the low back pain after the combination of treatment including physical therapy and SI joint rhizotomy; (2) current left buttock pain, most likely due to the piriformis muscle spasm which is often seen associated with SI joint dysfunction; (3) history of C5-6 disk herniation; (4) left shoulder pain, currently seeing Dr. Ahn with planned surgery in the future; (5) history of GERD, unable to tolerate Mobic; (6) previous MRI evidence of very early disk dessication probably at T12-L1, unclear of clinical significance. It was noted that Petitioner was still doing physical therapy, and it was noted that approval would be sought for left piriformis muscle injection followed immediately with physical therapy session for manual stretching. It was noted that Petitioner could continue on light duty per Dr. Ahn's recommendation, and that he was off work due to work's inability to accommodate light duty restrictions. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on November 6, 2014 for mid back pain. It was noted that Petitioner had already received treatment for the low back pain, left lower extremity pain including therapy, SI joint injections and rhizotomy. It was noted that Petitioner had mid back pain, left greater than right. The impression was that of (1) left-sided thoracolumbar pain with previous MRI evidence of disk degeneration at T12-L1; need a dedicated thoracic spine MRI to see if there is more disk degeneration or disk herniation in the thoracic spine; (2) other potential pain generator could be the thoracic facet DJD; (3) left-sided low back pain, possible left-sided facet DJD; (4) history of left-sided SI joint pain, seems to be doing well after the left SI joint rhizotomy; (5) left shoulder rotator cuff surgery done in July 2014. It was noted that Petitioner could continue a home exercise program and that Petitioner needed a dedicated thoracic spine MRI. It was noted that Petitioner would follow Dr. Ahn's light duty recommendation. Included with the records of Dr. Smith was an interpretive report for an MRI of the thoracic spine performed on December 22, 2014, which was interpreted as revealing minimal left paracentral disc extrusion at T5-6 and minimal right paracentral disc protrusion at T10-11 causing no impingement. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on January 8, 2015 for follow-up for left-sided mid back pain. It was noted that Petitioner indicated that he first reported that he had left-sided mid back pain when he had the initial injury at the ER, but that according to Dr. Smith's records this was

the first that they were working up for the left-sided mid back pain. The impression was that of (1) left-sided thoracolumbar pain with MR evidence of multilevel mild disc degeneration without focalized disc herniation in the left-sided thoracolumbar junction or neural impingement; (2) prior reports of minimal small disc herniation at the left T5-T6 and right T10-T11, of unclear clinical significance; (3) history of left SI joint pain; (4) history of neck pain, seen by Dr. Kovalsky; (5) left shoulder pain with rotator cuff surgery done in July 2014. It was noted that Petitioner reported that his mid back pain actually started with therapy at the Centralia therapy program, and that it was causing some numbness in the mid back and that the pain was sometimes on the left side and sometimes on the right side; no additional therapy for the mid back was recommended. Approval was to be sought for a left-sided medial branch block for the thoracolumbar junction. It was noted that Petitioner was off work recommended by Dr. Kovalsky regarding the neck pain, and that he also had light duty restrictions regarding the shoulder recommended by Dr. Ahn. A left T11, T12, L1 and L2 medial branch block under fluoroscopic guidance was performed on February 1, 2015. (PX2).

The records of Dr. Smith reflect that Petitioner was seen on February 13, 2015 with a complaint of swelling after the medial branch block. It was noted that Petitioner had a lot of swelling in the back on both sides all the way up to the shoulder blades and down to the sacrum. The impression was that of (1) there is no evidence of post-injection complication after the left T11-L2 medial branch block; (2) complaint of increased neck pain with muscle tightness most likely due to muscle spasm; (3) history of low back pain; (4) overall diffuse spine pain after alleged work-related injury; (5) history of left shoulder with rotator cuff surgery done in July of 2014. Petitioner was instructed to continue his home exercise program. It was noted that Petitioner was scheduled to have confirmatory medial branch block the next week. It was noted that Petitioner could continue off work instructions recommended by Dr. Kovalsky because of neck pain. A left T11, T12, L1 and L2 medial branch block under fluoroscopic guidance was performed on February 17, 2015. It was noted that Petitioner was a candidate for rhizotomy. (PX2).

The medical bills of Dr. Aiping Smith were entered into evidence at the time of arbitration as Petitioner's Exhibit 3.

The *curriculum vitae* of Dr. Kovalsky was entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The off work slips issued by Dr. Kovalsky were entered into evidence at the time of arbitration as Petitioner's Exhibit 5.

The medical records of Dr. Kovalsky were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The records reflect that Petitioner was seen on September 11, 2013, at which time it was noted that he was a 50-year-old somewhat healthy male who was present for a chief complaint of neck pain with radicular arm pain associated with numbness and tingling in the left hand. It was noted that on December 20, 2012, Petitioner was involved in a motor vehicle accident in which he was driving a semi and was blown over by high winds, and that the truck rolled and landed on the driver's side. It was noted that subsequent to the accident Petitioner had neck and arm pain, and had been out of work since December of 2012. It was noted that Petitioner was being treated by his family physician, that he had physical therapy and had injection and epidurals with only minimal improvement of his pain. It was noted that Petitioner denied prior injury to his neck and denied prior numbness and tingling in his hand or arm. It was noted that Petitioner had a history of lower back problems, but not cervical problems. It was noted that the clinical diagnosis was thoracic outlet syndrome, post-traumatic whiplash syndrome and disc herniation C5/6 and C6/7 with mild left cervical radiculopathy. It was noted that Petitioner was recommended to undergo physical therapy for thoracic outlet syndrome and he was to "continue out of work." It was noted that if there was no improvement of his symptoms by December, then they would consider scheduling him for an anterior discectomy and fusion at C5/6 and C6/7. (PX6).

The records of Dr. Kovalsky reflect that Petitioner was seen on October 23, 2013, at which time he reported 10-15% improvement of his pain. It was noted that Petitioner was still having pain at the

occipital/cervical junction which was mild, and that more of the pain was at the cervicothoracic junction. It was noted that Petitioner had electrical shooting pain into his left scapula and down in the upper part of his arm, and that he also developed arm pain left greater than right with overhead activities or driving. It was noted that Petitioner was complaining of stiffness in his left hand which he was told was coming from his neck, but clearly he had tendon repairs in his left hand and the stiffness or inability to make a complete tight fist was not coming from his neck. It was noted that Dr. Kovalsky was not willing to do surgery until he was at least 12-14 months out from the accident because if he had whiplash syndrome the surgery was not really going to help him. It was noted that Petitioner did not have severe pathology in his cervical spine, that he had moderate to mild spondylosis at 5/6 and what appeared to be a small left-sided disc osteophyte complex, and that he had some early degenerative changes with maybe a small tiny central disc at C6/7. It was noted that Dr. Kovalsky recommended that Petitioner continue therapy for his brachial plexopathy in his neck, and that he did not think Petitioner had absolute restrictions that he could not work but it was his choice. It was noted that Petitioner stated that some of his other problems with his hand and lower back were keeping him from working more than his neck was. (PX6).

The records of Dr. Kovalsky reflect that Petitioner was seen on November 15, 2013, at which time it was noted that he was diagnosed to have cervical disc herniation at C6/7 on the left, central herniation with some spondylosis at C5/6 and a brachial plexopathy left side greater than right. It was noted that over the last week Petitioner had increased right-sided neck pain with numbness and tingling radiating down into this arm, and that he had had no falls, trauma or new injuries since last month. It was noted that Dr. Kovalsky wanted to wait 12-14 months from his injury and that if he continued to have neck and arm pain they would get a new MRI, and that if there were still disc herniations he would be a candidate for cervical discectomy and fusion. It was noted that Dr. Kovalsky had no explanation for the new onset of right neck and arm pain. It was noted that Petitioner would remain out of work and return in 8 weeks. At the time of the January 10, 2014 visit, it was noted that clinically Petitioner had multiple problems including a whiplash-related syndrome, spondylosis at 5/6 with some foraminal narrowing bilaterally and no major disc herniations on his recent MRI in August. It was noted that Petitioner had a left brachial plexopathy or post-traumatic brachial plexus stretching, and that he probably had left carpal tunnel syndrome. It was noted that Petitioner felt that therapy helped him, but that he was still having neck pain and headaches and some radiation into his shoulder blades worse on the right than the left. Petitioner was instructed to return in 6 weeks and if he was still having a lot of neck pain and the EMGs were unremarkable, Dr. Kovalsky would consider scheduling Petitioner for a cervical discectomy and fusion at C5/6. (PX6).

The records of Dr. Kovalsky reflect that Petitioner was seen on March 7, 2014, at which time it was noted that Dr. Kovalsky was not anticipating surgical intervention for the whiplash-related syndrome. It was noted that Petitioner had a mild brachial plexus stretching injury on the left, and that he had some extensive tendon injuries which were surgically repaired and were doing well. It was noted that Petitioner had post-traumatic carpal tunnel syndrome, left shoulder pain and also left SI joint dysfunction. It was noted that Petitioner's neck pain had significantly improved and that he was having less pain, headaches or muscle spasm. It was noted that Petitioner was having anterior shoulder pain with overhead activity, some tingling in his arm and symptoms of carpal tunnel, and that the SI injection was wearing off and he was having recurrent left buttock pain. Petitioner was recommended to undergo another SI injection, and he was referred to Dr. Ahn for definitive treatment of the left shoulder rotator cuff tear and carpal tunnel release. It was noted that if Petitioner's SI joint was doing well then he should be placed into work conditioning/hardening and get him back to work, but that if his SI joint was bothering him then he would consider a short course of physical therapy and possibly minimally invasive SI joint fusion. It was noted that Petitioner was going to remain out of work at that point indefinitely. (PX6).

The records of Dr. Kovalsky reflect that Petitioner was seen on December 4, 2014, at which time it was noted that he had rotator cuff repair of his shoulder and was on his way to recovery and had for the

most part completed physical therapy. It was noted that Petitioner was currently being worked up for thoracic pain, and that he continued to have neck pain, headaches and radicular arm pain slightly worse on the right than left sides. It was noted that Petitioner did not feel his neck had improved at all. It was noted that Petitioner was to remain out of work and would be referred for an MRI of his cervical spine. It was noted that depending on the MRI findings, Petitioner may be a candidate for a cervical discectomy and fusion or possibly a disc replacement at C6/7. Included within the records was the interpretive report for an MRI of the cervical spine performed on February 26, 2015, which was interpreted as revealing degenerative disc disease. (PX6).

The records of Dr. Kovalsky reflect that Petitioner was seen on March 11, 2015, at which time it was noted that he had recovered form left shoulder rotator cuff repair but was still having neck pain, headaches and radicular left arm pain. It was noted that Petitioner had been approved for surgery but Dr. Kovalsky wanted to wait for him to recover from his shoulder surgery. It was noted that the new MRI scan revealed spondylosis with bilateral foraminal narrowing at C5/6 with some central stenosis, and a left central soft disc herniation out in the neural foramen causing clear compression of the C7 nerve root. It was noted that Dr. Kovalsky recommended an anterior cervical discectomy and fusion at C5/6, and that at C6/7 where he had the soft disc herniation without spondylosis he should have a discectomy and total disc arthroplasty. Petitioner was instructed to quit smoking. At the time of the July 2, 2015 visit, it was noted that Petitioner was having radicular arm pain left greater than right. It was noted that Dr. Kovalsky believed that Petitioner should have cervical surgery first, and that the carpal tunnel only took a few weeks to recover from. It was noted that Petitioner was unable to return to work. The clinical impression was that of persistent left post-traumatic carpal tunnel syndrome, cervical spondylosis and disc herniations with axial neck pain, cephalgia and radiculopathy, left greater than right. (PX6).

The medical bills of Dr. Kovalsky were entered into evidence at the time of arbitration as Petitioner's Exhibit 7.

The medical records of St. Anthony's Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The records reflect that Petitioner was seen on December 20, 2012 after a single vehicle semi rollover. It was noted that Petitioner did not remember the accident and did not know if he lost consciousness, and that he was complaining of left arm pain and dizziness as well as having scrapes and lacerations to the left forearm and scrapes to the left hand. The emergency room records reflect that Petitioner complained of low back pain when he tried to move. The impression at the time of discharge included head injury with loss of consciousness; laceration injury; location to left 4-5th knuckle; laceration to the left forearm 2 cm; and multiple skin cuts from shattered auto glass. The records reflect that Petitioner underwent a CT of the cervical spine on December 20, 2012, which was interpreted as revealing (1) no evidence of cervical fracture or dislocation; there is mild scoliotic deformity which may be due to spasm; (2) due to degenerative changes, mild narrowing of the neural foramina including at C3-C4 and C5-C6; (3) there are small spurs at the disk space C3-C4 of unknown age; (4) at the level of C5-C6, there is some concern about the appearance of the intervertebral disk left of the midline where there may be broad-based disk protrusion. The interpretive report for x-rays of the left forearm performed on the same indicated no fracture; radiopaque foreign bodies which have a rectangular appearance and may represent safety glass in the dorsum of the forearm; surgical exploration recommended. The interpretive report for x-rays of the left elbow performed on the same indicated no fracture, dislocation or fusion; radiopaque foreign bodies in the subcutaneous tissues consistent with safety glass. The interpretive report for x-rays of the left hand also performed on the same indicated no fracture or dislocation; radiopaque foreign bodies as described. The interpretive report for a CT scan of the lumbar spine also performed on the same revealed possible transverse process fracture of L2 on the right versus segmentation anomaly. (PX8).

The medical bills of KMB Services Corporation were entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The medical records of Salem Family Health Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The records reflect that Petitioner was seen on March 6, 2013 by Mary Piper, APN, at which time it was noted that he was being seen for a recheck of back pain and hand stiffness. It was noted that Petitioner's neck pain was 3-4/10 with pain intermittently to the left arm with headache frequently. The assessment was that of lumbar strain, herniated cervical disc and contusion of the hand with intact skin surface. Petitioner was instructed to follow up with Dr. Steinke as scheduled for evaluation of neck pain, therapy as ordered, follow up with the hand specialist as scheduled and to return for any new symptoms. At the time of the February 6, 2013 visit, Petitioner was being seen for a recheck of back and neck pain and a left hand laceration. It was noted that Petitioner was having persistent pain to the low back radiating to the left hip down to the left calf, that he had neck stiffness and pain with headaches with any increased activity, that he had headaches 4 days of the last week, that his pain to the neck was worse with flexion and that he had intermittent pain to the left shoulder and arm. The assessment was that of neck strain, lumbar strain, contusion of the hand with intact skin surface and open wound of the hand. Petitioner was instructed to continue physical therapy, undergo an MRI of the cervical spine, was given a referral to Dr. Steinke for neck and back pain and was given a referral to Dr. Ahn for left hand swelling and weakness of the left ring finger. (PX10).

The records of Salem Family Health Center reflect that Petitioner was seen on January 23, 2013 for follow-up of the left arm and hand wounds and low back pain, as well as upper back, neck and across the shoulder pain. The assessment was that of lumbar strain, and Petitioner was instructed to undergo the MRI as scheduled the next day. At the time of the January 7, 2013 visit, Petitioner was seen for a recheck of the left arm and was also noted to have complaints of low back pain. It was noted that Petitioner was having low back pain after standing for 30 minutes. The assessment was that of lumbar strain and open wound of the hand. Petitioner was recommended to start physical therapy for the lumbar spine. At the time of the December 28, 2012 visit, Petitioner was seen for a recheck of lacerations to the left forearm and hand, and it was noted that he continued to have pain in the left hand and forearm. The assessment was that of contusion of the hand with intact skin surface and late effects of an open wound of the upper extremities. Petitioner was recommended to undergo repeat x-rays of the left hand and to use Vaseline gauze to the lacerations. At the time of the December 21, 2012 visit, it was noted that Petitioner was being seen in follow-up from a semi accident while working, and that he had multiple injuries including his head, left knuckle, left forearm and skin lesions. The assessment was that of open wound, and Petitioner was given a script for Norco. (PX10).

Included within the records of Salem Family Health Center was an interpretive report for an MRI of the cervical spine performed on February 12, 2013, which was interpreted as revealing (1) degenerative changes, with disc protrusion/extrusion impinging somewhat on the anterior thecal space posterior to the C5-6 level; the posterior elements also show some degree of hypertrophy at that level contributing to a narrowed appearance of the spinal canal at C5-6; (2) other milder degenerative changes are also noted at C6-7 to the left of midline best seen on the axial image; (3) there may be slight narrowing of the right greater than left neural foramen due to a disc osteophyte complex at C3-4. Also within the records of Salem Family Health Center was an interpretive report for an MRI of the lumbar spine performed on January 24, 2013, which was interpreted as revealing (1) the vertebral body heights, alignment and disc spaces are preserved; (2) no spinal stenosis or neuroforaminal narrowing is seen; (3) the intervertebral discs are unremarkable in the lumbar segment of spine, but slight decreased signal at the T12-L1 disc could represent early dessication and very mild degenerative change there. (PX10).

The medical bills of St. Mary's Work Safety were entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The medical records of St. Mary's Work Safety were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. The records reflect that Petitioner underwent a Physical Therapy Cervical Evaluation on October 1, 2013 with a referral diagnosis of sprain of neck, and that he underwent

physical therapy for the timeframe of October 1, 2013 through January 14, 2014. At the time of the October 14, 2013 session, it was noted that Petitioner stated that he was a little more sore from doing more around the house over the weekend. At the time of the December 23, 2013 visit, it was noted that Petitioner stated that he just wanted his doctor to make a decision on what to do so he could get better and get back to work, and that he also stated that he felt like he had made little to no improvement in the last year and still had constant pain as well as numbness and tingling. (PX12).

The records of St. Mary's Work Safety reflect that Petitioner underwent a Physical Therapy Shoulder Evaluation on April 9, 2014 for a referral diagnosis of pain in joint, shoulder region; rotator cuff (capsule) sprain. The records reflect that Petitioner underwent physical therapy for the timeframe of April 9, 2014 through April 28, 2014. The records further reflect that Petitioner underwent a Physical Therapy Shoulder Evaluation on July 29, 2014 for a referral diagnosis of pain in joint, shoulder region, left; status post rotator cuff repair. The records reflect that Petitioner underwent physical therapy for the timeframe of July 29, 2014 through December 1, 2014. (PX12).

The medical records of Orthopaedic Center of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. The records reflect that Petitioner was seen on January 8, 2015 for follow-up for left-sided midback pain. It was noted that Petitioner was last seen by Dr. Smith on November 6, 2014 for his left-sided thoracolumbar pain with previous MR reports of disc degeneration at T12-L1. It was noted that a dedicated thoracic spine MRI was done on December 22, 2014 that showed no evidence of a fracture, irregular endplates with Schmorl's nodes multilevel, minimal level paracentral disc extrusion at T5-T6, minimal right paracentral disc protrusion at T10-T11 causing no impingement, and mild facet degenerative joint disease multilevel. It was noted that Petitioner reported that he had left-sided midback pain when he had the initial injury at the emergency room, but according to Dr. Smith's records this was the first time that Petitioner was being worked up for left-sided midback pain. The impression was that of (1) left-sided thoracolumbar pain with MR evidence of multilevel mild disc degeneration without focalized disc herniation in the left-sided thoracolumbar junction or neural impingement; (2) prior reports of minimal small disc herniation at the left T5-T6 and right T10-T11, of unclear clinical significance; (3) history of left SI joint pain; (4) history of neck pain; (5) left shoulder pain with rotator cuff surgery done in July of 2014. It was noted that Petitioner reported that his midback pain actually started with therapy, and that it was causing some numbness in the midback and pain sometimes on the left and right sides. It was noted that approval would be sought for a left-sided medial breach block x 2 for the thoracolumbar junction, and that if Petitioner had a positive response they may consider rhizotomy. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on December 17, 2014 by Dr. Ahn, at which time it was noted that he had mild soreness in the anterior lateral corner of the shoulder area. Petitioner was released for the shoulder at that time, and it was noted that he would probably require work hardening after his back treatment was done by a spine surgeon. At the time of the November 26, 2014 visit with Dr. Ahn, it was noted that Petitioner was currently doing well and that with heavy resistive activity he as complaining of 4-5/10 discomfort. Petitioner was to be scheduled for work hardening. At the time of the October 29, 2014 visit with Dr. Ahn, it was noted that Petitioner was currently doing well without complaints and that at rest there was no pain. It was noted that Petitioner was to be set up with an aggressive strengthening program and was to remain on light duty. At the time of the October 1, 2014 visit with Dr. Ahn, it was noted that Petitioner was currently doing well without complaints, was rating his pain a 0/10 but was having quite a bit of neck discomfort. Petitioner was instructed to undergo physical therapy and was placed on light duty work restrictions. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on September 3, 2014 by Dr. Ahn, at which time it was noted that he was doing well without complaints and that his pain was improving. Petitioner was to be set up with therapy and placed on light duty work

restrictions. At the time of the July 23, 2014 visit with Dr. Ahn, it was noted that Petitioner was doing well without complaints and his pain was under control at 3/10. Petitioner was taken off work until the sling and swathe came off the arm. It was noted that Petitioner underwent left shoulder arthroscopy and exam under anesthesia, supraspinous rotator cuff tear repair with double row suture anchors and subacromial decompression on July 17, 2014 at Good Samaritan Surgery Center. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen by Dr. Ahn on June 23, 2014, at which time it was noted that surgery was cancelled due to a large engorged tick on the posterior aspect of his shoulder. It was noted that surgery was to be rescheduled. At the time of the June 16, 2014 visit with Dr. Ahn, it was noted that surgery was scheduled but Petitioner had a large tick that was engorged that was seen on the posterior aspect of the shoulder near the surgical site. At the time of the April 30, 2014 visit with Dr. Ahn, it was noted that the cortisone injection and therapy were done but the symptoms were not any better. It was noted that the shoulder therapy had exacerbated the neck symptoms and Petitioner was having quite a bit of difficulty. The clinical impression was that of left shoulder rotator cuff deep partial tear. Petitioner elected to proceed with surgery. It was noted that Petitioner was also having moderate carpal tunnel symptoms on the left side which were bothering him and that he was wondering whether that could be treated while he was recovering from shoulder surgery. It was noted that approval would be sought. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen by Dr. Ahn on April 2, 2014, at which time it was noted that he complained of left shoulder pain since December of 2012. It was noted that Petitioner was driving a semi and was blown over by wind and injured his shoulder and back. It was noted that Petitioner recently had an MR arthrogram which showed a deep partial tear of the supraspinatus tendon, and that the MRI showed a degenerative tear of the posterior labrum. It was noted that Petitioner was having significant difficulty with overhead activity and lifting activity. The clinical impression was that of left shoulder rotator cuff tendinopathy/deep partial tear. It was noted that a short course of conservative treatment would be started. At the time of the August 22, 2013 visit with Dr. Smith, Petitioner was seen for neck pain and bilateral upper extremity pain. It was noted that Petitioner reported an 8-month history of sudden onset worsening constant pain in the back of the neck as well as involving the bilateral posterior thigh, dorsal forearm with more constant pain on the left, intermittent pain in the right upper extremity as well as numbness and tingling involving the fingers and weakness of the bilateral upper extremity. The impression was that of (1) 40% bilateral neck pain, 60% pain in the bilateral upper extremity, left greater than right, with MRI evidence of degenerative disc disease at C5-6; the left upper extremity pain and paresthesias could be due to the disk herniation at C5-6; (2) history of low back pain without MRI evidence of degenerative disc disease; the pain could be due to SI joint dysfunction, facet syndrome or superimposed with degenerative disc disease; (3) other medical co-morbidities including history of hypertension, GERD, arrhythmia, low back pain, cervical pain and left hand/ring finger surgery. Petitioner was to continue his home exercise program and he was recommended to undergo a new MRI of the cervical spine in preparation for his consultation with Dr. Kovalsky since his pain did not respond well to the epidural steroid injection. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on April 8, 2013 by Dr. Conrardy, at which time it was noted that since the motor vehicle accident on December 20, 2012, he had had pain in his neck and left upper extremity. It was noted that the pain was primarily in the lower region of the cervical spine and radiated down the left arm posteriorly all the way to the thumb and index fingers on the left upper extremity. The impression was that of (1) cervical spondylosis; (2) cervical degenerative disc disease; (3) displaced cervical disk; (4) cervicobrachial syndrome; (5) unknown cardiac arrhythmia. Petitioner was recommended to proceed with a cervical epidural injection on the left as requested by Dr. Steinke. At the time of the April 1, 2013 visit with Dr. Steinke, it was noted that Petitioner had left worse than right neck pain radiating up to his occipital region as well as down between the scapula, and that he had some radiation of symptoms in his left posterior arm as well as occasionally

down into his left thumb and index finger. It was noted that Petitioner had been taking pain medications and Ibuprofen with no real improvement of his symptoms, that he had had 3-4 weeks of physical therapy without significant improvement and that he had never had any cortisone injections or surgeries on his cervical spine. Petitioner was recommended to undergo a left-sided C5/6 transforaminal injection and he was taken off work. (PX13).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on February 25, 2013 by Dr. Steinke, at which time it was noted that he had left worse than right neck pain radiating both up into the occipital region as well as down between his scapula and that he had a little bit of radiation into his left posterior arm as well. It was noted that Petitioner's neck pain started within a day or two of the injury, and that the pain distribution was 100% neck, 0% upper extremity. Petitioner was referred for physical therapy and was taken off work. At the time of the February 13, 2013 visit with Dr. Ahn, it was noted that his complaint was that of left hand fourth and fifth finger stiffness. It was noted that Petitioner was involved in a motor vehicle accident and that the left forearm was dragged against the pavement and had some embedded glass in the forearm area and also a laceration of the dorsal aspect of the MIP joint of the middle, ring and little finger. It was noted that Petitioner was having some stiffness and inability to fully extend the finger. The clinical impression was that of left forearm foreign body/ring and little finger stiffness on the left hand MP joint area secondary to post-traumatic stiffness. (PX13).

Included within the records of Orthopaedic Center of Southern Illinois was an interpretive report for an MRI of the thoracic spine performed on December 22, 2014, which was interpreted as revealing minimal left paracentral disc extrusion at T7-8 and minimal right paracentral disc protrusion at T10-11 causing no impingement. An MRI of the left shoulder performed on March 3, 2014 was interpreted as revealing (1) high-grade partial interstitial and bursal surface tearing of the mid to posterior supraspinatus and anterior infraspinatus tendons; (2) mild AC joint arthrosis with small subacromial spur; (3) fibrillation and degenerative tearing of the posterosuperior labrum; (4) mild subacromial subdeltoid bursitis. An MRI of the cervical spine performed on August 30, 2013 was interpreted as revealing (1) moderate right uncovertebral hypertrophy at C3-4 contacting the exiting right C4 nerve root; (2) moderate central disc protrusion at C5-6 causing mild central canal stenosis and contacting the exiting C6 nerve roots; (3) small left paracentral disc protrusion at C6-7 contacting the exiting left C7 nerve root. (PX13).

Also included within the records of Orthopaedic Center of Southern Illinois was an operative performed by Dr. Ahn dated July 17, 2014, at which time Petitioner underwent (1) left shoulder arthroscopic supraspinous rotator cuff tear repair with double row suture anchors; (2) left shoulder arthroscopic subacromial decompression; (3) left shoulder diagnostic arthroscopy and examination under anesthesia for a pre- and post-operative diagnosis of (1) left shoulder subacromial impingement/rotator cuff tear. The records reflect that Petitioner also underwent a C5-6 translaminar epidural steroid injection on August 5, 2013 for a pre- and post-procedure diagnosis of left C5-6 disk herniation with left upper extremity radiculopathy, and that he also underwent a C6-7 translaminar epidural steroid injection on July 18, 2013 for a pre- and post-procedure diagnosis of left C5-6 disk herniation with left upper extremity radiculopathy. The records further reflect that Petitioner underwent a cervical epidural steroid injection at C7-T1 on the left side on June 24, 2013 for a pre- and post-procedure diagnosis of cervical spondylosis, cervical degenerative disc disease, displaced cervical disc and cervicobrachial syndrome. (PX13).

The medical records and bills of Good Samaritan Surgery Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. The records reflect that Petitioner underwent a left endoscopic carpal tunnel release on January 21, 2016 by Dr. Ahn for a pre- and post-operative diagnosis of left carpal tunnel syndrome. (PX14).

The medical records of Salem Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. The records reflect that Petitioner was seen on December 2, 2015

for "follow-up." It was noted that Petitioner's "problems" included, among others, degeneration of intervertebral disc, and it was noted that he reported arthralgias/joint pain. The assessment was that of hyperlipidemia and hypertensive disorder. At the time of the March 19, 2015 visit, Petitioner was seen for smoking cessation. It was noted that he had an upcoming cervical fusion and needed to quit smoking. The records reflect that Petitioner underwent a pre-operative physical on May 29, 2014 for a proposed rotator cuff and labral repair. At the time of the September 4, 2013 visit, Petitioner was seen for fluctuating blood pressure and neck/back pain. It was noted that Petitioner had a transverse L4 process fracture that healed, and that he had persistent neck pain and spasm of the paraspinals in the mid and lower back. (PX15).

The Wage Statement was entered into evidence at the time of arbitration as Petitioner's Exhibit 16.

The medical records of Orthopaedic Center of Southern Illinois (11/5/15-6/15/16) were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. The records reflect that Petitioner was seen by Dr. Kovalsky on June 15, 2016, at which time it was noted that he had neck pain, headaches and radicular left arm pain with some questionable incidence of thoracic outlet syndrome. It was noted that approval for surgery was sought. The clinical impression was that of left cervical radiculopathy and axial neck pain due to spondylosis at C5/6, and disc herniation at C6/7 on the left. Petitioner's Hydrocodone scripts were issued. At the time of the March 11, 2016 visit with Dr. Kovalsky, it was noted that Petitioner injured his cervical spine, shoulder, left forearm and left wrist in the accident, and that he had made a complete recovery from his carpal tunnel surgery in January. It was noted that Petitioner was still complaining of neck pain and headaches with pain radiating into his left shoulder blade, and numbness and tingling in the forearm and hand involving mainly the index, long and to a lesser degree, ring finger of the left hand. It was noted that Petitioner was a candidate for a 2-level anterior cervical discectomy, epidural decompression and interbody fusion at C5/6, C6/7 level. It was noted that a new cervical MRI would be needed prior to surgery to make sure the soft disc herniation at C6/7 was not resorbed. It was noted that if surgery was not approved by May, Petitioner was to follow-up in June for med management. The clinical impression was that of chronic neck pain, cephalgia and left cervical radiculopathy due to cervical spondylosis at C5/6, cervical spondylosis at C6/7 with a work-related disc herniation at C6/7 on the left with C7 radiculopathy. Petitioner was instructed to remain off work. (PX17).

The records of Orthopaedic Center of Southern Illinois reflect that Petitioner was seen on February 22, 2016 for reevaluation of the bilateral endoscopic carpal tunnel releases. It was noted that Petitioner was currently doing well without complaints. Petitioner was discharged by Dr. Ahn at that time. At the time of the January 27, 2016 visit with Dr. Kovalsky, it was noted that if Petitioner's carpal tunnel release did not get rid of the majority of his arm pain then he would be a candidate for cervical discectomy and fusion. It was noted that Petitioner was still complaining of neck pain and headaches, and pain in his arm that radiated from his neck on the left side down to his shoulder blade and down into his forearm and thumb. It was noted that if Petitioner failed to have significant improvement 6-8 weeks status post carpal tunnel surgery, the plan would be to repeat a cervical MRI and consider surgery based on the MRI findings. At the time of the January 25, 2016 visit with Dr. Ahn, it was noted that Petitioner was doing well without complaints after his left endoscopic carpal tunnel release one week prior. At the time of the January 11, 2016 visit with Dr. Ahn, it was noted that Petitioner had complaints of left hand numbness and tingling in the radial three digits mostly, and that his symptoms started after an accident in 2012 when his truck was blown over by high-speed winds. The clinical impression was that of left carpal tunnel syndrome/probable very early cubital tunnel syndrome. Surgery was recommended. (PX17).

The transcript of the evidence deposition of Dr. Kovalsky was entered into evidence at the time of arbitration as Petitioner's Exhibit 18. Dr. Kovalsky testified that he is board-certified in orthopedic surgery and has a subspecialty in spinal surgery. He testified that he assume the care of Petitioner when Dr. Steinke left the practice, and that he first saw Petitioner on September 11, 2013. He testified that

subsequent to the motor vehicle accident, Petitioner was having neck pain, left shoulder and left arm pain, and that he was also having lower back pain and pain in his left buttocks as well as headaches. He testified that Petitioner denied ever having problems or being treated for any of these conditions before. He testified that his diagnosis after taking the history, performing the examination and reviewing the diagnostics was that of whiplash syndrome, thoracic outlet syndrome or post-traumatic brachial plexopathy and a disk herniation at C6-7 on the left with radiculopathy and a spondylosis with a superimposed disk herniation at C5-6 which could be contributing to Petitioner's neck and left arm pain. (PX18).

Dr. Kovalsky testified that Petitioner's symptoms throughout treatment for the most part have pretty much stayed the same, that his arm pain has gotten a little worse and that his thoracic outlet symptoms have improved. He testified that the MRI from February of 2015 showed the same findings, that the soft disk herniation was still present at C6-7 on the left and that he had spondylosis at C5-6, which was never going to improve radiographically because it was a degenerative condition. He testified that he recommended that Petitioner have a cervical fusion at C5-6 and a disk replacement at C6-7. (PX18).

Dr. Kovalsky testified that the right arm pain referenced in the November 15, 2013 note was a symptom that would be more likely related to thoracic outlet syndrome which often can be bilateral, and that it would not be uncommon for an individual to have some symptoms on the opposite side. He testified that for the most part, the majority of Petitioner's symptoms had all been on the left side. He testified that he believed that Petitioner's carpal tunnel syndrome was related to the motor vehicle accident, and was based on Petitioner's history that he denied ever having any of the symptoms prior to the accident. He testified that he referred Petitioner to Dr. Ahn for the rotator cuff tear and the carpal tunnel syndrome, because he did not treat either condition surgically. He testified that Petitioner did not have gross neurological weakness, so he did not feel he imperatively needed to have cervical surgery, so he suggested that Petitioner get his shoulder fixed first. (PX18).

Dr. Kovalsky testified that when he saw Petitioner on December 4, 2014, he had done relatively well with recovering from the shoulder surgery and that his symptoms with regard to the neck and left arm were unchanged. He testified that Petitioner had ongoing neck pain and headaches, predominantly on the left side, and that he still had referred neurological pain into his left arm which was reproduced with physical examination. He testified that he would not do surgery based on an MRI that was over a year old, so he recommended a new MRI which looked pretty much the same. He testified that he suggested that Petitioner undergo neck surgery, and, because he was also complaining of thoracic pain, he obtained a thoracic MRI. He testified that Petitioner had stopped smoking per his recommendation. (PX18).

Dr. Kovalsky testified that Petitioner has had the same symptoms, in essence, for almost three years and had failed conservative treatment, and that he had abnormal pathology on both his EMG nerve conduction studies and also his cervical MRI. He testified that he has treated Petitioner's cervical spine injury and thoracic outlet syndrome/brachial plexopathy since September 11, 2013, and that it was his opinion that Petitioner sustained injuries to his cervical spine during the course of the motor vehicle accident at issue. He testified that he felt that Petitioner's carpal tunnel syndrome was post-traumatic and related to the accident, and that the thoracic outlet syndrome was a result of the deceleration injury. He testified that the treatment rendered to Petitioner was reasonable and necessary as a result of the injuries sustained in the accident of December 2012. He further testified that Petitioner's inability to work was due to the various injuries he sustained as a result of the accident in December of 2012. He testified that he believed that Petitioner was not going to improve with observation or conservative management and should have surgery on his cervical spine, that there was no specific surgical treatment of thoracic outlet syndrome so Petitioner was going to have to deal with it, and that Petitioner had failed conservative treatment of the carpal tunnel syndrome and would require surgical intervention. (PX18).

Dr. Kovalsky testified that he believed that the updated cervical MRI, cervical surgery and carpal tunnel syndrome surgery were procedures that were causally related to the semi accident of December 2012. He testified that the medical bills as contained in Petitioner's Exhibit 7 (attached to the deposition transcript) represented standard billing in the Southern Illinois area, and were reasonable and necessary for the treatment of Petitioner's conditions that he suffers from. (PX18).

On cross examination, Dr. Kovalsky testified that he did not have opportunity to review a cervical MRI that was performed in February of 2013. He agreed that he never saw the emergency room records at St. Anthony's, and testified that the only records that he looked at were those of Dr. Steinke and Dr. Conrardy. He testified that he never specifically asked Petitioner when he complained of neck pain following his accident, and testified that he assumed that it started after the accident. (PX18).

On cross examination, Dr. Kovalsky testified that most of the pathology at C5-6 was a pre-existing degenerative condition, and that there were no fractures and no acute bony injury. He testified that there was a small central disk herniation, but it was impossible to state whether or not that was from the accident or was pre-existing. He testified that there was no way of dating when the disk herniation occurred based on looking at the MRI scan. (PX18).

On cross examination, Dr. Kovalsky testified that EMGs were not a good way to document a radiculopathy unless the individual had significant nerve compression. He testified that the EMG report of November of 2013 showed no findings consistent with a cervical radiculopathy. He agreed that when he initially treated Petitioner, he wanted to see if the whiplash syndrome would resolve in 12-14 months post-accident. He testified that if Petitioner had a large disc herniation with neurological deficits, he would have recommended that he have surgery. He agreed that the MRI arthrogram showed rotator cuff pathology that ultimately required surgery. He agreed that Dr. Cantrell, in his first IME report, diagnosed Petitioner correctly. (PX18).

On cross examination, Dr. Kovalsky testified that it was possible that the pathology at C6-7 preexisted the motor vehicle accident. He testified that Petitioner's thoracic outlet syndrome was still present with relatively mild ongoing symptoms and agreed it was not disabling. He agreed that without any other injuries or pathologies, the thoracic outlet syndrome would not be disabling Petitioner from his current work. He testified that he has not done a nicotine screen on Petitioner and would not do that until surgery had been approved. He agreed that he would cancel the surgery if the nicotine screen was positive. (PX18).

On cross examination, Dr. Kovalsky agreed that Petitioner had undergone epidural steroid injections to his cervical spine and that they gave short-term but no long-term improvement. He testified that he agreed with Dr. Cantrell's opinions that he did not appreciate any signal change within the spinal cord of the cervical spine area, that there was an absence of any definite cord compression and that there were no appreciable changes between the two MRI studies of August 2013 and February 2015. He testified that with another MRI he would be looking at whether or not the disc material had reabsorbed at C6-7, which would indicate to him that the arm pain was not coming from there. He agreed that the pain generator that he was looking at fixing was the cervical radiculopathy into the left arm and some axial neck pain. (PX18).

The transcript of the evidence deposition of Dr. Smith was entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Dr. Smith testified that she is board-certified in physical medicine and rehabilitation as well as pain medicine, and that her practice is mainly non-operative. She testified that Petitioner was referred to her by Dr. Steinke for low back pain. She testified that her impression as of the time of the first visit was that of SI joint pain, for which she recommended pain medications, an SI belt, continued home exercise program and a left SI joint injection. She testified that if patients did not receive long-term benefit from the injections, then they would be a candidate for a rhizotomy. (PX19).

Dr. Smith testified that after the injection was performed, Petitioner reported 60% improvement. She testified that she recommended that Petitioner continue on medications, a home exercise program and that he undergo a rhizotomy procedure for SI joint pain. She testified that Petitioner underwent another SI joint injection on March 25, 2014 as Dr. Kovalsky wanted him to have more therapy for the SI joint pain while he was receiving treatment for the left shoulder. She testified that when she saw Petitioner on April 4, 2014, he continued to complain of pain in the left of the lower back and felt there was a popping in and popping out phenomenon which was usually suggesting instability of the SI joint. She testified that she added physical therapy with a specific therapist who had undergone special training for SI joint pain. (PX19).

Dr. Smith testified that a rhizotomy was ultimately performed on May 27, 2014 at the left L5 and S1, S2 and S3. She testified that when she next saw Petitioner on July 3, 2014, he was still complaining of pain and reported 50% improvement of the low back pain after the combination of SI joint rhizotomy and physical therapy. She testified that she requested peripheral muscle injection followed with physical therapy. She testified that when Petitioner returned on November 6, 2014, he was complaining of mid back pain and her impression was mid back pain, left greater than right. She agreed that the therapist indicated in September of 2014 that Petitioner was complaining of mid back pain at that time. (PX19).

Dr. Smith testified that she discussed with Petitioner on January 8, 2015 the results from the MRI of the thoracic spine, which revealed multilevel disc degeneration. She testified that the degeneration could be preexisting, but she felt Petitioner's pain was more from facet syndrome which could be related to his low back pain or the initial injury. She testified that the treatment plan at that time was to obtain approval for a medial branch block for the thoracolumbar pain. She testified that the injections were ultimately performed, and that because Petitioner reported complete pain relief, it suggested he was a good candidate for the rhizotomy. She agreed that she has not performed the rhizotomy on the thoracic spine at T11-L2. She testified that she last saw Petitioner on February 17, 2015. (PX19).

Dr. Smith testified that she believed that the injury to the SI joint level was or could have been caused by the accident of December 20, 2012. With regard to the treatment of the thoracolumbar junction, Dr. Smith testified that she believed that the injuries might be related to the accident of December 20, 2012. She testified that if there were preexisting issues with Petitioner's thoracic spine, the accident might or could have aggravated such preexisting conditions in his spine. She testified that the treatment provided by her from July 25, 2013 through February 17, 2015 was reasonable and necessary as a result of the accident of December 20, 2012. She testified that she believed that Petitioner would require further medical treatment to that area of his body if he still had pain, and that the rhizotomy to the thoracolumbar area was still necessary if Petitioner still had pain. She testified that she believed that the rhizotomy to the thoracolumbar area was causally related to the injuries sustained in the accident of December 20, 2012, and that the rhizotomy was reasonable and necessary as a result of the accident. She further testified that the treatment provided was reasonable and necessary, and that the charges incurred were reasonable. (PX19).

On cross examination, Dr. Smith agreed that she has primarily treated Petitioner for the low and mid back conditions, but that her first encounter with him was for the injection in his neck. She agreed that the current treatment for Petitioner's cervical spine was being coordinated by Dr. Kovalsky. She agreed that she would defer to the other treaters as to Petitioner's neck and shoulder. (PX19).

On cross examination, Dr. Smith testified that she did not believe that Petitioner had true thoracic outlet syndrome, and testified that she did not diagnose him as suffering from a brachial plexus injury. She testified that she did not make that conclusion, but in order to confirm the diagnosis an EMG was typically necessary. She testified that she agreed with the radiologist's interpretation of the MRI of December 22, 2014. When asked if she had any opinions as to whether or not any possible disc extrusion at T5-6 was causing Petitioner's current symptomatology, Dr. Smith responded that she could not say for

sure because she did not focus on the disc herniation because Petitioner's pain was mainly a little lower than that. (PX19).

On cross examination, Dr. Smith agreed that she did not know for sure whether Petitioner had pain in the mid back all along. She agreed that the natural progression of a degenerative condition of the thoracic spine can include the onset of symptoms of pain over time. She agreed that because of the second positive response to injection, she recommended the rhizotomy to the area where the two medial branch blocks were performed. She testified that Petitioner has some facet arthropathy in the thoracic spine but her impression was that of facet syndrome, and agreed that facet syndrome could come from a number of situations including facet degenerative joint disease but also trauma or posture. She testified that the pain generator in Petitioner's low back pain has most likely been the SI joint. (PX19).

On cross examination, Dr. Smith testified that she has not placed Petitioner under any work restrictions secondary to the SI joint because he was always on restrictions from some other pathology. She testified that she would probably at least place Petitioner on light duty if there was availability, and that she will usually request an FCE if there were no other issues preventing them from going back to work full duty. She testified that she did not think that Petitioner had received enough treatment to say that he had reached maximum medical improvement. (PX19).

The transcript of the evidence deposition of Dr. Russell Cantrell dated December 17, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. Dr. Cantrell testified that he is board-certified in physical medicine and rehabilitation. He testified that his first examination of Petitioner took place on January 15, 2014, at which time Petitioner reported that he was involved in a tractor-trailer accident on December 20, 2012 when he was traveling on a secondary road near Effingham when a gust of wind caused his truck to roll onto the driver's side. He testified that Petitioner reported no prior troubles with his neck, low back or any upper extremity symptoms. He testified that Petitioner reported numbness in his left upper extremity and involved his first three digits of his left hand, and that there was also sharp pain in the ulnar aspect of his left wrist. (RX1).

Dr. Cantrell testified that he reviewed various medical records and radiographic studies. He testified that with respect to the MRI of the cervical spine dated August 30, 2013, he did not see any evidence of a lateralizing disc herniation, but Petitioner had multilevel degenerative disc disease from C3-4 through C6-7. He testified that he did not see any distortion or signal changes within the spinal cord, which was important to him because Petitioner had some upper motor neuron findings on his clinical examination. He testified that the EMG dated November 1, 2013 confirmed the existence of carpal tunnel syndrome on the left, and also demonstrated that there were no cervical radicular findings. (RX1).

Dr. Cantrell testified that he was of the opinion that Petitioner was not experiencing symptoms of cervical radiculopathy at the time of the exam on January 15, 2014 based on various issues including the distribution of Petitioner's complaints and the absence of myotomal weakness. He testified that he believed that Petitioner had left shoulder pathology for which he recommended a work-up, which was to include an MRI arthrogram. (RX1).

Dr. Cantrell testified that following Petitioner's shoulder surgery, he had a second opportunity to examine him and that the examination took place on June 22, 2015. He testified that Petitioner reported that since he had last been seen, he had undergone arthroscopy and repair of the rotator cuff tear by Dr. Ahn and that he had participated in post-operative physical therapy but was not advanced into a conditioning or work hardening program due to ongoing symptoms he was having in his neck, mid and lower back. He testified that Petitioner underwent an updated MRI of his cervical and thoracic spines, and that he underwent additional thoracic and spinal injections which provided transient relief of his symptoms. He testified that Petitioner also reported that based on his response to the injections a

radiofrequency ablation procedure had been recommended but not yet performed, and that based on the results of the updated cervical MRI, Dr. Kovalsky was recommending surgery. (RX1).

Dr. Cantrell testified that his review of the MRI of the thoracic spine revealed findings that were degenerative in nature, and that he did not see any evidence of disc herniations or any evidence of spinal cord compression. He testified that it was his opinion that while Petitioner may have sustained a cervical strain, the diagnosis was superimposed on pre-existing degenerative changes, and that he did not feel that Petitioner had developed an acute radiculopathy as a result of the work injury. He testified that he considered the prognosis for the cervical surgical recommendation to be guarded. (RX1).

Dr. Cantrell testified that in his opinion, Petitioner did not require any further treatment for the left shoulder, and that there were no restrictions to Petitioner's work activities with regard to the left shoulder. He testified that he was of the opinion that Petitioner's lumbar spine did not require any further treatment, but that he would encourage Petitioner to continue with an exercise program. He testified that the combination of the diagnostic studies, physical therapy records, clinical exam findings and positive response to the SI joint injections suggested that Petitioner had a sprain to the SI joint as a cause of his symptoms. He further testified that Petitioner did not require any work restrictions with regard to the lumbar spine or sacroiliac joint, nor did the cervical spine condition require any work restrictions. (RX1).

Dr. Cantrell testified that he was of the opinion that Petitioner would not require any further procedural pain management for the thoracic spine based on his reported temporary response to the medial branch blocks. He testified that he did not believe Petitioner required any work restrictions with regard to the thoracic spine complaints. He testified that he did not believe that a cervical surgery was reasonable and necessary, nor were any further treatment or diagnostic studies necessary. (RX1).

On cross examination, Dr. Cantrell testified that he believed that Petitioner's shoulder injury was causally related to the semi accident, and that the surgery was reasonable and necessary as a result of the accident. He testified that he believed that the carpal tunnel syndrome was causally related to the work accident, and that Petitioner had soft tissue injuries to his left hand and wrist area. He testified that the carpal tunnel syndrome surgery was necessary to alleviate the problem. He agreed that Petitioner reported that he did not have any complaints, pain or problems with his neck prior to the work accident. He testified that he did not find any reason to believe that the accident aggravated the degenerative neck condition given that there was an absence of any preexisting complaints and there was an absence of neck symptoms for days or weeks after the accident. (RX1).

On cross examination, Dr. Cantrell agreed that in his note of March 11, 2015, Dr. Kovalsky indicated that the Spurling's test was markedly positive on the left and negative on the right. He testified that he did not have a clear explanation for the difference over the span of three months, but testified that Dr. Kovalsky had also documented other positive findings at points in the past. When asked if he agreed that Petitioner sustained injuries to the SI joint as a result of the accident, Dr. Cantrell responded that it was reasonable to conclude that Petitioner had a strain to his SI joint from the accident. He testified that the treatment to the SI joint was reasonable and necessary as a result of the work accident. He testified that he believed that Petitioner sustained strain and sprain injuries to the thoracic spine from the work accident, and agreed that the injury to the hand and surgery that was performed on the hand was related and necessary as a result of the accident. (RX1).

On cross examination, Dr. Cantrell testified that he believed that Petitioner would likely benefit from the carpal tunnel release, followed by time off and light duty activities thereafter as well as a few sessions of therapy following surgery. He agreed that when he last saw Petitioner, he was still having pain in his neck, mid back and low back. He testified that he would not advocate narcotic medications for Petitioner's chronic muscular symptoms, but that it would not be unreasonable for him to take non-steroidal anti-inflammatory medication. He testified that he thought it was probable that Petitioner would

continue to report pain symptoms in the neck, thoracic spine and lumbar spine/SI joint due to the chronicity to which he had reported them over three years. He agreed that he does not perform surgeries. (RX1).

On redirect examination, Dr. Cantrell testified that surgeons had specialized surgical techniques but that did not necessarily also give them specialized diagnostic techniques. He testified that it was not the pain but the radiation that would give a positive finding for a Spurling's test. He testified that for the test to be positive at the C5-6 and C6-7 levels, it would cause pain down into the hand into the radial aspect of the hand, into the thumb, middle and index fingers. (RX1).

The transcript of the evidence deposition of Dr. Russell Cantrell dated July 6, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. Dr. Cantrell testified he had the opportunity to perform an additional IME on May 23, 2016. He testified that Petitioner reported that since he had last been seen, he had undergone a left carpal tunnel release by Dr. Ahn and that the surgery had led to partial improvement in the symptoms he was having in his thumb, index and middle fingers but there was no change in symptoms he was having in the fourth and fifth fingers of his left hand. He testified that Petitioner reported that he continued to have left-sided neck pain radiating intermittently to his left arm and that any activity that required abduction of his left shoulder at or above 90 degrees of abduction caused an increase in his arm symptoms, particularly in the fourth and fifth fingers. He testified that Petitioner denied any relief with placing his left hand on his head, and that it served to exacerbate his left arm symptoms. (RX2).

Dr. Cantrell testified that the lack of relief of symptomatology when placing his left hand on his head was relevant in that it was a position of relief for individuals who had cervical radiculopathy. He testified that the lack of any symptomatic relief when performing that maneuver suggested a lack of cervical radiculopathy, and that the reproduction of symptoms would suggest something other than a cervical radiculopathy because if the symptoms were cervical spine in origin, then movements of the shoulder would not in and of themselves cause symptoms to worsen. He testified that the costoclavicular movement did nothing to alter the position of the cervical spine and would do nothing to cause impingement of a nerve root, so for it to replicate a person's symptoms would also indicate that cervical radiculopathy was not the likely source of Petitioner's symptoms. (RX2).

Dr. Cantrell testified that in the initial post carpal tunnel syndrome evaluation by Dr. Ahn dated January 25, 2016, Petitioner was complaining of ongoing numbness and tingling in the ulnar two digits, but then by the evaluation by Dr. Kovalsky on March 11, 2016, the numbness and tingling was mainly involving the index and long finger and to a lesser degree the ring finger, moreso on the radial side. He testified that the migration of symptoms over the course of six months was relevant because if the symptoms were always originating from the cervical spine and from the C5-6 and C6-7 nerve roots, then the symptoms would have been fixed in the distribution assuming that was the cause of the complaints. He testified that if you considered the variability in clinical findings along with the variability in the distribution of Petitioner's symptoms, along with considering that his symptoms were in the fourth and fifth fingers which was in the distribution of the C8 nerve root and there was no pathology identified at the C7-T1 level where the C8 nerve root exited, these were all relevant in reaching the conclusion that he did not believe that Petitioner would benefit from a surgical fusion at the 5-6 and 6-7 levels. (RX2).

Dr. Cantrell testified that he was of the opinion that Petitioner did not require the cervical fusion surgery that was being recommended by Dr. Kovalsky, and testified that he was not comfortable in saying that Petitioner had pathology that was consistent with his symptoms and therefore did not have pathology that he could reasonably predict would improve his symptoms post-operatively. He testified that he did not believe that Petitioner required any additional treatment for his left carpal tunnel condition, and that he believed that no restrictions were necessary with regard to his left carpal tunnel condition. (RX2).

On cross examination, Dr. Cantrell agreed that Dr. Kovalsky had seen Petitioner may times more than he had over the course of his treatment since the accident. He agreed that when Petitioner presented on May 23rd, he was still complaining of symptoms in his hands and fingers and that it was 3-4 months after his carpal tunnel surgery. He agreed that since the carpal tunnel surgery in January of 2016, Petitioner had continued to complain of left-sided neck pain and that it radiated intermittently into the left upper extremity. He testified that Petitioner indicated that he was still having pain in his neck that would radiate down into the mid back to his low back, and even into his left leg. (RX2).

On redirect examination, Dr. Cantrell testified that his findings when he palpated the left pectoralis minor muscle was that of recreation of Petitioner's left hand symptoms into the fourth and fifth fingers which was indicative of referred myofascial pain. He testified that he did not know whether he believed that Petitioner had thoracic outlet syndrome, but he believed that given the nature of the surgery Petitioner underwent for his shoulder and the symptoms that were found on examination, that more likely than not he was experiencing left arm symptoms that were referred myofascial pain rather than cervical radicular in nature. (RX2).

The IME report of Dr. Russell Cantrell dated January 15, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 3. The IME report of Dr. Russell Cantrell dated June 22, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The IME report of Dr. Russell Cantrell dated May 23, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 5.

The medical records of St. Anthony's Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records were duplicative of those as contained in Petitioner's Exhibit 8. (RX6; PX8).

The medical records of Orthopedic Center of Southern Illinois were entered into evidence at the time of arbitration as Respondent's Exhibit 7. The records were effectively duplicative of those as contained in Petitioner's Exhibits 2, 6, 13 and 17, but also contained records pertaining to a left T11, T12, L1 and L2 medial branch block performed on February 10, 2015 by Dr. Smith for a pre- and post-operative diagnosis of left-side thoracolumbar pain, facet DJD. Additionally, the records of Orthopedic Center of Southern Illinois reflect that Petitioner was seen by Dr. Kovalsky on December 4, 2014, at which time it was noted that he was diagnosed by EMG nerve conduction studies to have carpal tunnel syndrome predominantly on the left side, and that he also had rotator cuff dysfunction on the left from decelerating into the shoulder harness. It was noted that Petitioner continued to have neck pain, headaches and radicular arm pain slightly worse on the right then left sides, and that he did not feel that his neck had improved at all. It was noted that Dr. Kovalsky did not believe that Petitioner's ongoing symptoms were a residual whiplash, and that he had findings on previous MRI of a central disc herniation at C5/6 and a right central disc herniation at C6/7. It was noted that Petitioner stated that if Dr. Kovalsky felt he was a candidate to have surgery then he would be willing to do it. It was noted that Petitioner would be referred for another MRI of his cervical spine and, depending on MRI findings, he may be a candidate for a cervical discectomy and fusion or possibly even a disc replacement at C6/7. (RX7; PX2; PX6; PX13; PX17).

The medical records of Good Samaritan Surgery Center were entered into evidence at the time of arbitration as Respondent's Exhibit 8. The records were effectively duplicative of those as contained in Petitioner's Exhibit 14. (RX8; PX14).

The medical records of Barnes Jewish Hospital were entered into evidence at the time of arbitration as Respondent's Exhibit 9. The records reflect that Petitioner was seen on April 26, 2013, at which time he underwent removal of left forearm foreign body with exploration and repair of partial extensor tendon lacerations, left ring and small finger at MCP joints with irrigation and debridement of

left dorsal hand wound. The post-operative diagnoses were that of foreign body, left forearm with partial extensor tendon lacerations, left small and ring fingers MCP joint. (RX9).

The medical records of Salem Medical Center were entered into evidence at the time of arbitration as Respondent's Exhibit 10. The records were effectively duplicative of those as contained in Petitioner's Exhibit 15. (RX10; PX15).

The medical records of Washington University School of Medicine Department of Neurological Neuromuscular Electrodiagnostic Laboratory were entered into evidence at the time of arbitration as Respondent's Exhibit 11. The records reflect that Petitioner underwent nerve conduction studies on November 1, 2013, which were interpreted as revealing electrodiagnostic evidence for a moderate left carpal tunnel syndrome and no electrodiagnostic evidence for ulnar neuropathy or for a left braxial plexopathy. (RX11).

The medical records of Salem Family Health Center were entered into evidence at the time of arbitration as Respondent's Exhibit 12. The records were effectively duplicative of those as contained in Petitioner's Exhibit 10. (RX12; PX10).

The medical records of SSM Health St. Mary's Centralia were entered into evidence at the time of arbitration as Respondent's Exhibit 13. The records were duplicative of those as contained in Petitioner's Exhibit 12. (RX13; PX12).

CONCLUSIONS OF LAW

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

The Arbitrator places greater reliance upon the opinions of Drs. Smith and Kovalsky in this case in finding that Petitioner's current condition of ill-being is causally related to the accident of December 20, 2012. The Arbitrator notes that Dr. Smith opined that the semi-truck accident of December 12, 2015, might or could have caused the injuries to Petitioner's low back, SI joint and mid back, and that if Petitioner still has pain in the low back, SI joint or mid back, he will require future medical treatment to that part of the body, including the thoracolumbar rhizotomy. (PX19).

The Arbitrator further notes that Dr. Kovalsky also testified that as a result of the accident, Petitioner sustained injuries to his cervical spine, including a left-sided disk herniation at C6/7, a small central disk herniation at C5/6, on top of the preexisting spondylosis, with left cervical radiculopathy. Dr. Kovalsky further testified that his treatment of Petitioner, including the cervical issues, were all related to the injuries he received in the accident and would be reasonable and necessary as part of the normal treatment for those conditions. (PX18).

Having reviewed the evidence in its entirety, having considered Petitioner's testimony at the time of arbitration regarding his ongoing symptomatology, and having placed greater reliance upon the opinions of Petitioner's treating board-certified orthopedic surgeon, Dr. Kovalsky (who has examined and treated Petitioner on a relatively regular basis since the accident), as compared to the opinions proffered by the Section 12 physician, Dr. Cantrell, whose non-surgical practice is dedicated to physical medicine and rehabilitation, the Arbitrator finds that Petitioner met his burden of proving that his current condition of ill-being is causally related to the accident of December 20, 2012.

With respect to disputed issue (G) pertaining to earnings, the Arbitrator finds that the wage statement in this case reflects that Petitioner earned a total of $42,728.73 in earnings for the 49 weeks' worth of earnings information provided for the timeframe of December 24, 2011 through December 15, 2012. (PX16). The Arbitrator notes that no information was provided on the wage statement as to whether the earnings included any overtime pay, nor was any evidence proffered by Respondent so as to dispute Petitioner's testimony that he regularly worked overtime. Based on the foregoing, the Arbitrator finds that Petitioner's average weekly wage was that of $872.01.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of December 20, 2012. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 3, 7, 9, 11, 14 and 17, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Drs. Kovalsky and Smith, including, but not limited to, the recommended cervical surgery (and precedent pre-operative cervical MRI) and the thoracic rhizotomy.

With respect to disputed issue (L) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from December 20, 2012 through July 14, 2016. (AX1).

The Arbitrator notes that Petitioner has not been allowed to return to work in a full duty capacity by any of his treating physicians since the date of accident of December 20, 2012. Petitioner testified he was never advised by Respondent that light duty was available, and that on the day after the accident he was told by his supervisor, Scott Mahon, that there was no light duty work and that he would have to be "100%" before he came back to work. Petitioner further testified that he called into his employer every week for 3½ years providing them with an update and talking to the dispatcher. The Arbitrator notes that no evidence was presented by Respondent that light duty was available and/or offered to Petitioner. Accordingly, the Arbitrator finds that Petitioner was temporarily and totally disabled for the timeframe of December 20, 2012 through July 14, 2016, a total of 185 4/7 weeks. Respondent is entitled to a credit for the temporary total disability benefits already paid in the amount of $48,666.46 as stipulated to by the parties at the time of arbitration. (AX1).

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

RAYMOND A. COLLETTI,

Petitioner,

vs.

NO: 09 WC 003690

17IWCC0494

STANDARD PARKING,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions 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, causal connection, evidentiary issues, and nature and extent and being advised of the facts and law, modifies the Decision of the Arbitrator as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

The Commission modifies the award to find Petitioner sustained 7.5% loss of the whole person as provided in Section 8(d) 2 of the Act. The Commission bases this conclusion on the diagnosis made by Dr. Newman of non-union of a fracture of the posterior 10th rib on the right side. On April 6, 2010 the Petitioner was released to his regular job as a cashier by Dr. Newman with a permanent lifting restriction of five pounds. At the time of release from care Petitioner continued to have tenderness over his right back, restricted range of motion, and pain when rotating his trunk. Petitioner testified that he continues to experience pain and stiffness in his upper right back and side.

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $360.09 per week for a period of 63 5/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner

17IWCC0494

the sum of $324.08 per week for a period of 37.5 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of 7.5% 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 $29,100.00. 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 14 2017
o-06/29/17
SM/msb
44

Stephen J. Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

COLLETTI, RAYMOND A
Employee/Petitioner

Case# **09WC003690**

STANDARD PARKING
Employer/Respondent

17IWCC0494

On 9/22/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0147 CULLEN, HASKINS NICHOLSON
DAVID B MENCHETTI
10 S LASALLE ST SUITE 1250
CHICAGO, IL 60603

0766 HENNESSY & ROACH PC
ERICA A LEVIN
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

17IWCC0494

Raymond A. Colletti
Employee/Petitioner

v.

Case # 09WC003690

Consolidated cases: Not applicable

Standard Parking
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 **L. Thompson-Smith**, Arbitrator of the Commission, in the city of **Chicago**, on **July 18, 2016**. 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 ____

17IWCC0494

FINDINGS

On 12/26/2008, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $20,086.76; the average weekly wage was $540.13.

On the date of accident, Petitioner was 50 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 $4,681.17 for TTD, $0 for TPD, $0 for maintenance, and $1,440.36 for a permanent partial disability advance, for a total credit of $6,121.53.

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

ORDER

Respondent shall pay to the Petitioner temporary total disability benefits of $360.09 per week for 63 & 5/7 weeks, commencing December 27, 2008 through March 18, 2010, as provided in Section 8(b) of the Act.

Respondent shall pay to the Petitioner permanent partial disability benefits of $324.08 per week for 25 weeks because the injuries sustained caused 5% loss of the whole person as provided in Section 8(d)2 of the Act.

Respondent shall have credit against the awards above for payment of temporary total disability benefits and permanent partial disability benefits in the total amount of $6,121.53.

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) medical bills; 3) temporary total disability; and 4) the nature and extent of Petitioner's injury. *See,* AX1.

On December 26, 2008, Raymond Colletti ("Petitioner") was employed by Standard Parking ("Respondent") as a parking garage cashier. His duties required him to sit and stand in a booth and collect parking fees from customers. The job required Petitioner to twist from side to side in order to collect tickets and fees.

The parties have stipulated that on December 26, 2008, Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent. At that time, Petitioner was exiting his booth, slipped on ice and fell to the ground, landing on his right side. Petitioner immediately noticed pain on his right side. Petitioner signed an employee incident report indicating that he had hit his head and back; the time of the accident is listed as approximately 5:25 hours. RX 4.

On December 26, 2008, at approximately 12:59 hours, Petitioner was seen at Swedish Covenant Hospital complaining of falling on ice, pain in his ribs and hitting his head. X-rays revealed no rib fracture at that time and Petitioner was referred to Dr. Arminio Surucci for follow-up. PX 1, pp. 9-11.

On January 6, 2009, Petitioner followed-up with Dr. Surucci, complaining of a fall at work causing right-sided back pain. Dr. Surucci diagnosed back pain and rib contusion. On January 16, 2009 Dr. Surucci recommended an MRI due to Petitioner's persistent symptoms of pain in his back and posterior rib cage. PX 2, pp. 7-8.

MRIs of the thoracic and lumbar spine performed at Swedish Covenant Hospital on January 21, 2009 revealed mild changes. PX 1, pgs. 5 & 7.

On January 23, 2009, Dr. Surucci reviewed the MRIs, continued Petitioner off work and referred him for additional treatment. PX 2, pg. 5.

On February 12, 2009, Petitioner saw Dr. Daniel Newman. Petitioner was complaining of pain along the posterior right thoracic and upper lumbar region. Dr. Newman took an x-ray that revealed suspected fracture of the posterior 10th rib on the right side. Dr. Newman thought Petitioner had a nondisplaced fracture of the posterior 10th rib and recommended physical therapy and continuing medication. Dr. Newman kept the Petitioner off work and directly related Petitioner's complaints to his fall on December 26, 2008. PX 3, pp. 4-6.

On February 19, 2009, Petitioner began physical therapy at Advanced Rehabilitation Clinics (ARC) with an initial evaluation diagnosis of right 10th rib fracture and continued in physical therapy thereafter. PX 3, pg. 51.

X-rays performed by Dr. Newman on March 2, 2010, showed further healing of the noted fracture of the right rib and Dr. Newman reported that Petitioner was unable to return to his job as a cashier because it required him to turn from side to side and that type of movement caused pain. PX 3, pgs. 13 & 14.

On April 9, 2009, Dr. Newman performed a trigger point injection that relieved some of Petitioner's pain and increased his motion. On April 23, 2009 Dr. Newman repeated the trigger point injection, stopped physical therapy and restricted Petitioner work to no rotation of his body, such as twisting to receive tickets. PX 3, pp. 15-16.

On April 22, 2009, Petitioner was examined by Dr. Jesse Butler at the request of Respondent. Dr. Butler had no imaging studies that showed a fracture. Dr. Butler acknowledged that Dr. Newman had diagnosed a T10 rib fracture. Dr. Butler reported that there appeared to be a causal connection between the injury sustained and the pain that Petitioner was experiencing. Dr. Butler felt that the Petitioner's occupation as a cashier would not place any significant stress on Petitioner's injury. Dr. Butler stated that the petitioner's ability to perform any other job for the respondent was beyond the scope of his examination. RX 1, pp. 1-3.

On July 8, 2009, Dr. Newman released Petitioner as having reached maximum medical improvement ("MMI"). Petitioner had completed a work-conditioning program at ARC. Petitioner was released to return to work with a ten (10) pound lifting restriction. PX 3, pp. 20, 75.

On November 10, 2009, Petitioner returned to see Dr. Newman with continued complaints of pain. X-rays performed by Dr. Newman showed a non-union of the posterior 10th rib on the right side. Dr. Newman expressed no doubt about the diagnosis and reported that the non-union was obvious. In Dr. Newman's opinion, the petitioner's discomfort was directly related to the fall he sustained in December 2008. Dr. Newman restricted Petitioner to lifting no more than five (5) pounds. PX 3, pg. 21.
On January 5, 2010, Dr. Newman recommended that Petitioner use a bone-stimulator to promote healing of the rib fracture. On February 2, 2010, Dr. Newman recommended that Petitioner continue with the bone stimulator as x-rays showed that the fracture line was less visible suggesting healing. PX 3, pp. 24, 26.

On February 11, 2010, Petitioner was once again evaluated by Dr. Butler, at the request of the Respondent. Dr. Butler reported a healed rib fracture which was caused by the fall. Dr. Butler disagreed with the Dr. Newman's opinion regarding the non-union and released Petitioner at MMI with no restrictions. RX 2, pg. 2.

On April 6, 2010, Dr. Newman reported that Petitioner was still experiencing diffuse tenderness over the right, back area and that motion in the lumbar spine was guarded. Dr. Newman released Petitioner at MMI and he was to return to work as a cashier with a permanent five pound lifting restriction. PX 3, pg. 29.

On April 24, 2013, Petitioner was once again evaluated by Dr. Butler, at the request of the Respondent. Dr. Butler reported that Petitioner had diffuse tenderness over the right back area. Dr. Butler reported that Petitioner sustained an uncomplicated rib fracture with persistent, chronic, subjective discomfort in the region. RX 3, pp.2-4.

Petitioner introduced into evidence as exhibit 4, medical bills in the amount of $31,773.51, from Illinois Physicians Network. The bills are for physical therapy from February 19, 2009 through July 7, 2009 and for the bone stimulator used on December 15, 2009. After insurance payments and adjustments, the balance due is zero. In addition, the bills include prescriptions, in the amount of

$520.51, ordered from November 10, 2009 through January 12, 2010. After giving the respondent credit for insurance payments and adjustments, this balance due is zero. The parties have stipulated that Respondent shall have credit for all medical bills paid. PX 4, pp. 19, 20, 23; AX1.

Respondent did not offer to return Petitioner to work as a cashier. Petitioner acknowledged that Respondent offered to return him to work in a ground transportation position, which involves heavy lifting. Dr. Butler released the petitioner to return to his former job as a cashier. Dr. Newman gave Petitioner permanent light duty lifting restrictions of five pounds on April 6, 2010. Petitioner has claimed temporary total disability (TTD) benefits through March 18, 2010 and Respondent paid Petitioner TTD benefits to Petitioner through April 23, 2009. Petitioner ultimately returned to work in a clerical capacity for a car wash, after March 18, 2010. PX 3, pp. 29, 49.

Petitioner testified that he continues to suffer pain and stiffness in his right upper back and side. Prior to December 26, 2008, he had no medical treatment for or medical problems with his right upper back and side and was working full duty as a cashier for Respondent. Prior to December 26, 2008, Dr. Surucci did not indicate Petitioner was under any medical treatment or restrictions for his right upper back and side. PX 2, pg. 9.

CONCLUSIONS OF LAW

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

The Arbitrator concludes that the Petitioner's current condition of ill-being is causally related to the accidental injuries of December 26, 2008. A chain of events which demonstrates a previous condition of good health and a subsequent injury resulting in disability, is sufficient evidence to prove a causal nexus between the accidental injuries and the Petitioner's current condition of ill-being. *Cornbelt Energy Corp. v. IL Workers' Compensation Commission*, 2016 IL App. (3d) 150311WC, par. 29.

Prior to December 26, 2008, Petitioner was in good health. The parties have stipulated that Petitioner sustained accidental injuries that arose out of and in the course of his employment with Respondent on December 26, 2008. Petitioner slipped on ice and fell on that date, landing on his right side, noticing immediate pain in his right upper back and side. He received immediate medical treatment at Swedish Covenant Hospital. By February 12, 2009, Dr. Newman had diagnosed a fractured posterior 10th rib directly related to the fall. By April 22, 2009, Dr. Butler acknowledged Dr. Newman's diagnosis.

In November 2009, Dr. Newman diagnosed a non-union of the rib fracture, directly relating the non-union to the fall of December 2008. Dr. Butler acknowledged that x-rays from November 10, 2009, showed what appeared to be an established non-union of a rib fracture. The Arbitrator gives significant weight to the reports of Dr. Newman, who consistently reported a direct causal relationship between the accidental injuries of December 26, 2008 and the petitioner's condition of ill-being.

17IWCC0494

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?

The Arbitrator concludes that the medical treatment rendered to Petitioner by Dr. Newman from February 12, 2009 through April 6, 2010, including physical therapy, bone stimulation and medication was reasonable and necessary and related to the accidental injuries of December 26, 2008. The parties have stipulated that the respondent shall have credit for all medical bills paid by the Respondent. Bills introduced by the petitioner show a zero balance.

K. What temporary benefits are in dispute?

The Arbitrator concludes that the Petitioner was temporarily totally disabled for a period of 63 & 5/7 weeks, commencing December 27, 2008 through March 18, 2010. Dr. Newman released the petitioner with a permanent five pound lifting restriction on April 6, 2010, assuming that he was returning to work as a cashier. Petitioner has claimed TTD benefits through March 18, 2010. The respondent has stipulated that Petitioner was temporarily, totally disabled through April 23, 2009.

Even though Dr. Butler released Petitioner to return to work as a cashier, there is no evidence that Respondent offered to return Petitioner to work as a cashier. Respondent offered to return Petitioner to work in a ground transportation position and Petitioner testified that that position, involved lifting above the restrictions placed on him by Dr. Newman. Dr. Newman released Petitioner at MMI with a permanent five pound weight lifting restriction after the non-union of the rib fracture had healed sufficiently.

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

The Arbitrator concludes that Petitioner has sustained accidental injuries causing 5% loss of use of the whole person pursuant to Section 8(d)2 of the Act. The Arbitrator bases this conclusion on the diagnosis made by Dr. Newman of non-union of a fracture of the posterior 10th rib on the right side. Dr. Newman released Petitioner to MMI on April 6, 2010, with a permanent lifting restriction of five pounds. At that time Petitioner had diffuse tenderness over his right back area and Petitioner's range of motion was guarded and Petitioner noticed pain when rotating. Petitioner currently notices pain and stiffness is his upper right back and side.

17IWCC0494

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
09WC03690
SIGNATURE PAGE

Signature of Arbitrator

September 22, 2016
Date of Decision

SEP 22 2016

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

Steve Cheatham,
Petitioner,

17IWCC0495

vs.

NO: 12 WC 6361

Big Muddy Correctional Center,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 9, 2016, is hereby affirmed and adopted.

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

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

DATED: AUG 16 2017
o8/3/17
DLS/rm
046

Deborah L. Simpson
Deborah L. Simpson

David L. Gore
David L. Gore

Stephen J. Mathis
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

17IWCC0495

CHEATHAM, STEVE
Employee/Petitioner

Case# **12WC006361**

BIG MUDDY CORRECTIONAL CENTER
Employer/Respondent

On 2/9/2016, 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 0.42% 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

FEB 9 = 2016

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

17IWCC0495

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

Steve Cheatham
Employee/Petitioner

v.

Big Muddy Correctional Center
Employer/Respondent

Case # **12** WC **6361**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Mt. Vernon**, on **January 6, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **September 26, 2011**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

In the year preceding the injury, Petitioner earned **$57,920.20**; the average weekly wage was **$1,113.85**.

On the date of accident, Petitioner was **47** years of age, ***single*** with **1** dependent child.

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

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

The parties stipulated at the time of hearing that Petitioner was temporarily totally disabled for the timeframe of January 10, 2012 through December 5, 2012.

Respondent shall be given a credit of **$25,262.87** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$25,262.87**.

Respondent is entitled to a credit of **$5,628.82** in medical bills through its group medical plan under Section 8(j) of the Act.

ORDER

As stipulated to by the parties at the time of arbitration, Respondent shall pay the sum **$742.57**/week for a period of **47 1/7 weeks (for the timeframe of January 10, 2012 through December 5, 2012)** for temporary total disability benefits under Section 8(b) of the Act. Respondent shall be given a credit in the amount of **$25,262.87** for temporary total disability benefits already paid.

Respondent shall pay for treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012** as provided in Section 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement for treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012** from any health insurance provider and shall provide payment information to Petitioner relative to any credit due for treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012**. Respondent is to pay unpaid balances with regard to said medical expenses for treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012** directly to Petitioner. Respondent shall pay any unpaid, related medical expenses for treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012** according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner. Respondent shall reimburse Petitioner for all out-of-pocket expenses related to medical treatment rendered **during the timeframe of September 26, 2011 through February 9, 2012** directly to Petitioner.

Respondent shall be given a credit of **$5,628.82** in medical bills through its group medical plan under Section 8(j) of the Act.

As Petitioner failed to prove that his current condition of ill-being is casually related to his accident, the Arbitrator makes no conclusion of law as to the issue of permanent partial disability as this issue is rendered 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

2/3/16
Date

ICArbDec p. 2

FEB 9 - 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Steve Cheatham
Employee/Petitioner

Case # 12 WC 6361

v.

Consolidated cases: N/A

Big Muddy Correctional Center
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 51 years of age and still works for Respondent. At the time of his accident on September 26, 2011, he was working in the health care unit. At around 12:00 a.m. he got an inmate out of his wheelchair, and the inmate had Lou Gehrig's disease. Petitioner was attempting to get the inmate onto the stool and the inmate was falling, but Petitioner caught him and felt a pull on his shoulder. Petitioner testified that the temporary nurse later at approximately 5:00 a.m. tried to walk the same inmate back to his bed, and he had to catch the inmate from falling onto the floor and the nurse. He testified that he felt another pull in shoulder at that time. Approximately 30 minutes later, another inmate committed suicide. Petitioner was unable to put the deceased inmate onto a gurney and needed assistance from another correctional officer. He testified that he had pain in his right shoulder and neck, which was a shooting pain.

Petitioner testified that when it happened, he felt a felt pull and strain in right shoulder. He testified that he was able to move his shoulder at that time, but for the next three days he could not move his arm. He testified that he also had pain in the neck area as well. He saw Dr. Smith at Logan Primary Clinic, who referred him to physical therapy.

Petitioner testified that before this accident, he had a prior neck fusion which was from another work-related accident. He testified that he had returned to work 5-6 months before this accident, and had been able to do full duty without any issues and did not miss any work because of his neck. He testified that he had no issues with his right shoulder during the 5-6 months before this accident. He testified that he had been starting to be able to do things with his son after his neck surgeries, but since the accident he has not been able to do things with his son. He testified that he had been playing tennis and playing catch with his son, but was not able to do so after this accident.

Petitioner testified that after the accident, Dr. Smith put him on light duty. He testified that Respondent accommodated the light duty restrictions for 90 days until January 9, 2012, but that after that date, Respondent no longer accommodated so he was off work. He testified that Drs. Smith and Whitehead kept him on light duty. He testified that he also saw Dr. Gornet in January 2012 and April 2012, who also placed him on restrictions. He testified that he also saw Dr. Paletta for his shoulder pain. He testified that Dr. Gornet referred him to physical therapy.

Petitioner testified that between 2012 and February of 2015, he remained on light duty at the request of Dr. Smith. He testified that Dr. Smith retired, so he then went to Dr. Parks who also kept him on light duty. He testified that during his period of light duty, no injections were performed and he only

underwent therapy. He testified that the therapy helped some. He testified that he still has not felt relief of his neck and shoulder pain, but it has improved some. He testified that he went from being left-handed to right-handed. He testified that he has treated primarily with Drs. Smith, Parks and Whitehead for his neck and right shoulder pain. He testified that during December 6, 2012 through February 14, 2015, he received occupational disability benefits from Respondent.

Petitioner testified that he continues to have issues with his neck and shoulder, and that any extended above-shoulder work was a major strain and fatigued his arms within 20-30 seconds after he got his arms above his shoulder. He testified that he keeps his hair shorter now because it is harder to wash and comb. He testified that when his right arm is above shoulder it feels fatigued and there is a dull, numbing sensation and then his arms do not want to do anything. He testified that he had pain at the top of the shoulder joint, that there was also pain on the front and back of the right shoulder and that the muscle between his shoulder and neck tightened up like a knot. He testified that when he bends down to pick something up with his right hand, his arm locks on him which feels like a bad pinch and brings him to his knees and also brings tears to his eyes. He testified that it was difficult to pull his boots on.

When asked how his life has changed since the accident, Petitioner testified that he used to play ball all the time with his son and that he also went hunting and fishing. He testified that he hunts and fishes now, but it sometimes takes 3-4 days for him to recover afterwards because his shoulder and neck hurts. He testified that that he gets tension headaches when he does things because of the strain of his muscles. He testified that his activity level has gone down, and that he has gained 30 pounds since the accident. He testified that he does not lift much as he is afraid he will hurt himself, and that he does not lift anything overhead. He testified that if he goes hunting with his buddies, they do all the heavy work and he only shoots. He testified that he is right-handed, and has had to learn to do things with his left hand since the accident. He testified that he is able to hold a soda can in his right hand.

Petitioner testified that at work, his new major has kept him "in the bubble" so he is not around the inmates or doing heavy lifting. He testified that he works in the control pod and pushes buttons. He testified that his major said he would try to keep him in this capacity until he retires in approximately a year. He testified that if a fight were to happen among the inmates, he would be concerned. He testified that he continues to see his chiropractor once a week and pays the deductible out of his pocket.

On cross-examination, Petitioner agreed that he still considered himself to be right-hand dominant and that he did most activities with his right hand. He testified that he likes to fish for bluegill and catfish, but does not fish in tournaments. He testified that that he hunts duck and deer and still shoots his shotgun right-handed, but that it hurts. He testified that he hunts deer with a bow and had to buy a new compound bow, which he has shot one time since the accident and hit a deer. He testified that he pinched his shoulder blades to pull it back. He testified that that he has a crossbow permit, but he does not use a crossbow because it is too heavy to carry. He testified that he does not hunt as avidly as before the accident. He testified that he does not shoot but guides for his buddies for turkey hunting in the spring now.

On cross-examination, Petitioner agreed that, prior to 2011, he had prior problems with his right shoulder which he understood was residual pain running down from his neck into his shoulder. Petitioner agreed that in August of 2011 he had an MRI of right shoulder performed and was told that there was a minute tear. He testified that he was told that his problems were coming from his neck and not just his shoulder, as it ran down his arms into his elbows and hands. He agreed that in December of 2010 he had his shoulder examined by Dr. Paletta, who said there was possible arthritis which was pre-existing.

On cross-examination, Petitioner agreed that after the incident at issue he went back to see Dr. Paletta, and that he saw him in both January and February 2012. He agreed that in February of 2012 Dr. Paletta said that the majority of his symptoms were cervical in nature and radiating down into his arm and

shoulder from his neck, and that he stated that Petitioner was at maximum medical improvement as of February 9, 2012. He agreed that Dr. Paletta referred him back to see Dr. Gornet, who he saw on April 5, 2012. He agreed that Dr. Gornet ordered some imaging, and said that his work was good so could not see keeping him on light duty. He agreed that Dr. Gornet released him to full duty with no restrictions, but Petitioner indicated that he felt he could not do his job. He testified that in April of 2012 he had tremendous pain and headaches all the time. He agreed that at that time he been off work for several months because he had exhausted his 90 days of light duty, and that in April he had been restricted in his activities.

On cross-examination, Petitioner agreed that the next day on April 6, 2012, he saw Dr. Smith right after he saw Dr. Gornet. He agreed that his attorney requested an FCE, which was performed. He agreed that Dr. Smith returned him to work with light duty restrictions per the results of the FCE. He agreed that from April 2012 through February 2015, he was on light duty because of the FCE. He agreed that one of the FCE performers said he could do work within the medium level which was the level that was required by his job, but that given the nature of his surgeries he needed to be cleared by his neck surgeon before returning to work. He testified that Dr. Gornet said if could not handle his work they would reassess the situation, but he wanted Petitioner to try. He testified that he did not go back to Dr. Gornet because he was kept off work the whole time.

On cross-examination, Petitioner was unable to confirm whether or not he killed a turkey in April of 2012. He testified he did not recall killing the turkey referenced in the Department of Natural Resources documentation from April 12, 2012. He testified that on November 15, 2012 he killed a buck with a compound bow. When asked whether he killed a 12-point buck on December 13, 2014, Petitioner stated that he did not, and that they found it dead but he used his tag. He testified that he reported that he killed it with his compound bow so that he could use his tag. He testified that you cannot take a deer head out of the woods without a tag on it. He testified that he told the DNR program that he harvested the deer with his compound bow, but that he was not talking to a person when he called. Petitioner identified the deer shown on Respondent's Exhibit 10 as the deer he killed in 2012.

On cross-examination, Petitioner testified that since he returned to work in February 2015, he has been working full duty with no restrictions. He testified that he works 37.5 hours per week with no overtime. With regard to Dr. Whitehead's records that referenced low back pain, Petitioner testified that he believed the lumbar condition was related to his accident but agreed that he was not seeking recovery for it in this claim. He testified that he complained to Dr. Gornet about his low back issues and that Dr. Gornet said he would do surgery when he was ready. Petitioner testified that he saw Dr. Gornet about his low back at the same time that he sought treatment for this accident. Petitioner did not dispute Dr. Parks' note of March 30, 2012 which referenced that Petitioner had back pain since he was 20 years old and had flared up last week. He testified that he is not receiving injections from Dr. Gornet, but rather an unnamed physician whose office is located south of Herrin whom he saw at the referral of Dr. Whitehead.

The medical records of Logan Primary Care Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The records reflect that Petitioner was seen on September 26, 2011, at which time Petitioner presented for an injury. It was noted that an inmate had Lou Gehrig's Disease and was in a wheelchair, and that Petitioner tried to catch the inmate as he was falling out of the wheelchair. Petitioner later had to lift the inmate, and that in both occurrences he pulled his shoulder. Petitioner had had previous shoulder problems, and had an MRI of the right shoulder which showed supraspinatus and infraspinatus tendinopathy, surface tear conjoined tendon. Since the injury Petitioner had constant burning and was unable to raise his shoulder above chest level, and he had pain running up into his neck. It was noted that the year prior, Petitioner had a cervical laminectomy. He was assessed with rotator cuff tendinitis, and it was noted that it was to be determined if his injury was work-related. Petitioner was given restrictions and medications, and was referred to an orthopedic surgeon. A Work

Release dated September 29, 2011 placed Petitioner under restrictions of no prisoner contact and no use of the right shoulder above chest level. (PX1).

The records reflect that Petitioner returned on November 4, 2011, at which time he presented for hypertension, and it was noted that he had been having a lot of pain in his back, neck and right shoulder. Petitioner was helping an inmate and injured his right shoulder and had been seeing Dr. Smith, and he was waiting to see orthopedics. Petitioner thought his blood pressure was high due to pain. Petitioner was next seen on December 29, 2011, at which time he presented for a recheck and informed Dr. Smith that the State had done nothing about his referrals, and that Petitioner was in a position where his employer said he had to go to full duty or go on disability. Petitioner was not recovered enough to be able to do this, and his physical therapy had never been approved by worker's compensation. Petitioner was assessed with rotator cuff tendinitis, and was again referred to orthopedics. (PX1).

The records reflect that Petitioner returned on January 31, 2012, at which time it was noted that since the injury Petitioner had constant burning and was unable to raise his shoulder above chest level, and that Petitioner's pain ran up into his neck. Petitioner had seen a surgeon and had been started on physical therapy. Petitioner was assessed with rotator cuff tendinitis and cervicalgia, and was instructed to follow up with an orthopedic surgeon and a neurosurgeon. Petitioner was next seen on March 6, 2012, at which time it was noted that Petitioner showed some improvement overall but had been recommended to undergo another month of physical therapy. Petitioner was scheduled to see Dr. Gornet on April 5, 2012. Petitioner was assessed with rotator cuff tendinitis (which was noted to be "better") and cervicalgia, and was instructed to follow up with his neurosurgeon and continue physical therapy. (PX1).

The records reflect that Petitioner was seen on March 30, 2012 for a low back pain evaluation. Petitioner had low back pain since he was 20 years old and had bulging discs. He stated that the pain would come and go, and that it flared one week ago and became worse. Petitioner had gone to the chiropractor the day prior and was scheduled to go again the following week. Petitioner stated "I need something to get through the weekend." It was noted that Petitioner saw a neurosurgeon as well and was getting cortisone injections. He had pain radiating down his left lower extremity. Petitioner was assessed with low back pain and sciatica, and was instructed to follow up with his neurosurgeon as planned the following week. (PX1).

The records reflect that Petitioner was seen on April 6, 2012, at which time Petitioner reported that Dr. Gornet saw him and said he could work regular duty because he was unable to find anything wrong with him. It was noted that Petitioner's attorney was requesting a functional capacity evaluation, and that Petitioner was still hurting. Per Petitioner's request, an FCE was to be scheduled. Petitioner was next seen on May 4, 2012, at which time it was noted that Petitioner was still hurting. The FCE was reviewed and light duty restrictions were written per the results of the FCE. (PX1).

The records reflect that Petitioner was seen on June 4, 2012, at which time Petitioner reported that he remained unchanged and still had constant burning pain that still ran up into his neck. The chiropractor was still working with his neck and it was better, and he continued on light duty at work based on the FCE. Petitioner was next seen on July 5, 2012, at which time he stated that he remained unchanged and still had constant, burning pain that ran up into his neck and that he also seemed to be having more pain into the forearm. Petitioner still had slight numbness in the fingers in his right hand. (PX1).

The records reflect that Petitioner was seen on August 6, 2012, at which time Petitioner stated that he was worse with some swelling in his shoulder from not doing much of anything. The swelling was down that day, and he still had constant burning pain that ran up into his neck. Petitioner seemed to be having more pain into the forearm, and he still had numbness in the fingers of his right hand. Petitioner was next seen on September 6, 2012, at which time Petitioner presented for a recheck.

Petitioner was next seen on October 12, 2012, at which time he stated that he was no better, and had an IME set up in St. Louis in one week. Petitioner's employer required monthly visits to complete work notes. (PX1).

The records reflect that Petitioner was seen on November 12, 2012, at which time Petitioner stated that he was better but that his shoulder was very tender over the posterior AC joint. Petitioner was next seen on December 10, 2012, at which time it was noted that Petitioner was the same and was tender over the AC joint. Petitioner was subsequently seen on January 7, 2013, at which time no changes were reported. Petitioner was also seen on February 4, 2013, at which time it no changes were reported. (PX1).

The records reflect that Petitioner was seen on March 4, 2013, at which time it was noted that Petitioner's shoulder hurt over the AC joint and that his tendinitis was worse in his arms and elbows. Petitioner was also seen on April 1, 2013, at which time it was noted that Petitioner was scheduled to go to court regarding his injury. (PX1).

The medical records of Whitehead Wellness Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The records reflect that Petitioner was seen on October 24, 2011, at which time it was noted that he returned with complaints of mild to slightly moderate soreness of the lower back with some occasional radiating symptoms of the lower extremities. Petitioner also complained of soreness and discomfort into the right side of the neck radiating into the right shoulder/scapula. Petitioner stated that he had a new injury of the right shoulder that occurred several weeks ago, and he was assisting a nurse with an inmate at the prison when he suddenly reached out to grasp the inmate/nurse from falling. Petitioner stated that he had immediate pain into the right shoulder, and had been seen by his primary care physician and put on light duty. It was noted that no x-rays had been performed, and that he was waiting for orthopedic referral approval from worker's compensation. The diagnosis was noted to be acute right AC joint sprain with possible separation, exacerbation of the pre-existing cervical/dorsal myofascial pain also complicated by pre-existing cervical degenerative changes and segmental joint dysfunction, and lumbar degenerative arthritis/intervertebral disc syndrome with myofascial pain and segmental joint dysfunction. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on October 31, 2011, at which time it was noted that he stated that he was doing much the same as he was last week with most of his complaints of pain of the upper back and neck with pain bilateral extending from the lower cervical to the upper dorsal with Petitioner pointing to the upper trapezius muscle area. Petitioner still had his "usual complaints" of the right shoulder pain which was felt to be from the right AC joint sprain/strain. Petitioner was next seen on November 4, 2011 at which time he reported that he had been feeling slightly better especially in the upper back and neck. He reported continued moderate pain of the lower back slightly worse with weather changes and still had some pain radiating from the cervical/dorsal junction into the right shoulder/scapula and right upper arm along with pain in the right AC joint. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on November 16, 2011, at which time his chief complaint was left lower back and hip pain with some left leg sciatic neuralgia pin and pain and discomfort into the top of his head/neck with headaches. Petitioner was next seen on November 18, 2011, at which time Petitioner reported that he was doing better compared to his last treatment. He stated that he still had a mild dull headache but the overall upper back and neck pain and headache pain had improved since his last treatment. He still reported intermittent pain and still slightly moderate from the left lower back into the left hip/gluteal and buttock. Petitioner was next seen on November 23, 2011, at which time he reported that he was feeling somewhat better and reported that the headache frequency and intensity had been much less since he was last seen and treated. He reported a slight increase of left lower back pain with also a slight increase of pain radiating into the left hip/gluteal

and left sciatic neuralgia pain. Pain and tenderness was still present with some pain still present slightly moderate into the right AC joint and exacerbated by right shoulder abduction. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on November 30, 2011, at which time he stated that he had been doing a little better, and that he still had headaches but the overall intensity of the head and neck pain had been better and less frequent. Petitioner was next seen on December 8, 2011, at which time he presented with a chief complaint of upper back, neck and shoulder pain, right shoulder pain and headaches. Petitioner stated that the prior two days he had been having an increasing amount of tension bilaterally running up both sides of the neck into the back of the head with intense headaches, and he stated that he got relief by reclining, lying down and using moist heat. Petitioner was next seen on December 14, 2011, at which time he reported that he was feeling better since his last treatment, that he had little lower back pain and that he had improvement of upper back, neck and shoulder pain. He reported that the worst pain was from the right upper back/dorsal and shoulder into the right side of the cervical spine with still some mild dull headaches. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on December 21, 2011, at which time he reported an increase in left-sided lower back pain with also increased pain radiating into the left hip/gluteal and left buttock. He also reported a slight increase of pain across both shoulders into the cervical muscles bilaterally with the majority of pain still present on the right side along the suboccipital and cervical spine at the C1 and C2 level. Petitioner also had increased pain from the left lower lumbar spine into the left hip and gluteal, and he had some intermittent lumbar radiculopathy symptoms into the posterior left leg to the knee. Petitioner was next seen on December 29, 2011, at which time it was noted that he stated that he had a slight increase of left lower back pain with some intermittent left hip/gluteal and left upper leg sciatic pain. He also reported that the pain also remained into the upper right cervical spine along the back of the head/neck with a slight increase of pain and discomfort bilaterally across the upper shoulders into the cervical muscles. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on January 4, 2011 [*sic*]. It was noted that he had felt better since his last treatment stating that he had 45-60 minutes of massage therapy and believed it was able to relieve a lot of the spasms into the upper dorsal and cervical muscles. Petitioner had discomfort across both shoulders and into the cervical spine which was still slightly more aggressive to the right side. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on January 10, 2012, at which time he stated that since his therapeutic massage the week prior he had had less pain into the upper back, neck and across the shoulders. He stated that the pain and discomfort into the neck and shoulders was mildly present but the intensity of the pain and cervical range of motion appeared to be much better. The most aggressive area of pain continued to be the upper cervical spine with still some mild joint pain in joint restrictions at the C1 and C2 level. Petitioner was next seen on January 17, 2012, at which time it was noted that since his last couple of sessions of therapeutic massage he had considerable relief of the upper back, neck and across the shoulder pain. He also reported a decrease in the frequency of the headaches. His cervical range of motion, although still restricted, was better. The most aggressive area of pain and discomfort continued to be the suboccipital and C1 and C2 level and more aggressive to the right side. There was also less pain along the right AC joint region and less soreness and stiffness into the mid and upper dorsal spine. He also complained of back pain on that date, and it was noted that he still had symptoms of lumbar radiculopathy secondary to lumbar intervertebral disc syndrome with palpitations [*sic*] of lumbar degenerative disc disease. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on January 24, 2012, at which time he reported that the pain and discomfort across the upper back, neck and shoulders was still present but the intensity of pain and overall range of motion/mobility was better. He had some bicipital pain that seemed to radiate from the anterior right shoulder inferiorly to the right elbow. There was some

palpated pain and tenderness along the right bicipital tendon and right subacromial AC joint. The records reflect that Petitioner had underlying problems that would be chronic and irreversible consisting of lumbar intervertebral disc syndrome with spondylosis and post-surgical changes of the cervical spine. Petitioner had some chronic rotator cuff problems tersely on the right side with rotator cuff tedinosis and new injury of the right AC joint with some bicipital tendinosis. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on February 3, 2012, at which time he stated that he was recently seen by Dr. Gornet and Dr. Paletta. He was originally seen by Dr. Gornet for complaints of the cervical spine, and had x-rays taken of the lumbar spine and a CT of the cervical spine. Petitioner was referred for six weeks of therapy concerning the cervical spine and was referred to Dr. Paletta for examination and evaluation of the right shoulder complaints. It was noted that Petitioner had seen Dr. Paletta in the past for both right and left shoulder complaints but a new injury had taken place in September 2011 when he reached for an inmate who was falling. Dr. Whitehead felt that Petitioner may have sustained a mild AC joint strain. It was noted that Dr. Paletta's examination was apparently unremarkable but he did suggest a diagnostic ultrasound of the right shoulder. It was further noted that Dr. Paletta's opinion was that the cause of Petitioner's current pain which was cervical, supraclavicular and right shoulder may be cervical-related. Dr. Whitehead opined that part of Petitioner's continued pain and disability at multiple levels and joints was not only related to multiple injuries and subsequent surgeries, but also from lack of proper rehabilitation from the injuries and surgeries. It was suggested that six weeks of therapy would be helpful but Petitioner needed ongoing care and rehabilitation under the guidance of either a physical therapist occupational therapist or strength coach. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on February 10, 2012, at which time it was noted that he began rehabilitation with most of the therapy concerning strength training of the upper back and neck and some of the upper extremities. Petitioner had some mild soreness but overall his pain levels were much better of the upper back and neck with improved range of motion. His chief complaint was that of increasing low or back pain with some neuralgia symptoms slightly worse to the right side of the right hip and gluteal. Petitioner was next seen on February 21, 2012, at which time it was noted that he had been the same since his last treatment. He stated that he had been undergoing physical therapy for the upper back, neck and shoulder which had consisted of rehabilitation/exercise and massage. He stated that the pain levels of the upper back and neck were still improved and he contributed that improvement to the treatment over the last few weeks combined with therapeutic massage. It was noted that Petitioner may be plateauing and the treatment scheduled was to be decreased. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on March 6, 2012, at which time he stated that he had been feeling worse recently stating that he was back to regular work-related activities but stated that he could not recall anything specifically that had been aggravating but the back pain had been worse with sciatica into the left hip and gluteal into the posterior lateral left lower leg. He stated that he had been having relief in his cervical area, but that the pain had been gradually returning as a result of some increase in activities and long periods of sitting at work. Petitioner was next seen on March 20, 2012, at which time he stated that he had been feeling worse, that he was back to regular work-related activities but stated that he could not recall anything specifically that had been aggravating but the back pain had been worse with sciatica into the left hip and gluteal into the posterior lateral left lower leg. Petitioner had symptoms of lumbar intervertebral disc syndrome with sciatic neuralgia. Petitioner had myofascial pain mostly on the right side of the levator scapula trapezius and posterior lateral cervical scalenes with joint pain and joint restrictions into the right cervical/dorsal junction. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on March 29, 2012, at which time he reported that his low back pain continued to progress with pain much more aggressive on the left side with radiating pain into the posterior lateral left leg to the left ankle. Petitioner had expressed greater relief of the upper back, neck and right shoulder stating that the last two treatments had

provided substantial relief. Petitioner's dorsal and cervical spine findings were much better overall. Petitioner next returned on April 3, 2012, at which time he stated that his lower back discomfort had continued and that he had continued neuralgia pain into the posterior lateral left thigh and into the posterior lateral lower leg on the calf and lateral gastroc muscle. Petitioner stated that he noticed continued improvement over the last few weeks into the upper back, neck and right shoulder, and he stated that his pain into the back had been more aggressive and wondered whether the dominant pain into the lumbar spine had overridden the neck pain. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on April 10, 2012, at which time he stated that the intensity of his back and leg pain had been better over the last couple of weeks with treatment. Petitioner had recently been seen by Dr. Gornet in St. Louis and was released from care and therapy concerning the upper dorsal and cervical spine. Petitioner questioned whether any further evaluation or treatment could be provided concerning the lumbar spine, but no further discussion was had. It was noted that exam and evaluation of the dorsal and cervical spine was noting some mild joint pain but much improved with decreasing joint restrictions into the cervical/dorsal junction. Dr. Whitehead's opinion regarding the upper dorsal/cervical and right shoulder was that Petitioner was much improved overall, and that the continuation of pain and chronicity was likely the result of severity of the injury, post-surgical changes and lack of proper rehabilitation after surgery. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on April 30, 2012, at which time he stated that recently over the last 3-4 days he had had a slight increase of neck pain with headaches. Petitioner had a functional capacity exam which indicated difficulty with working at shoulder height and above as well as weakness of the upper extremities such as gripping. He was scheduled for a consultation with Dr. Newell regarding epidural injections. Petitioner was next seen on May 4, 2012, at which time he stated that he was doing a little better and that the left lower back and left leg sciatic pin had been slightly less recently. He also described a slight decrease of pain and spasm of the upper dorsal and cervical muscles since he had been last seen, and the intensity of the pain to the right shoulder and scapula had been less as had his headache pain. Petitioner was scheduled for an epidural injection of the lumbar spine on Monday and would return on Tuesday for ultrasound therapy. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on May 8, 2012, at which time it was noted that he had undergone an injection the day prior and had considerable relief thus far with still a little bit of neuralgia pain into the distal left lower extremity but considerable decreased lower back pain. Petitioner reported that his upper back and neck pain had also been much better. Petitioner next returned on May 11, 2012, at which time he stated that the intensity of the lower back pain had been less with also less left leg sciatic neuralgia pain. He also reported a significant reduction of pain recently of the upper back and cervical spine, also reporting no headaches. Petitioner was next seen on May 16, 2012, at which time he stated that he may have aggravated his back after sitting on bleachers watching a ball game for about two hours. He also described a slight increase of upper back discomfort, but reported that the upper back and cervical spine were much better overall. Petitioner was also seen on May 18, 2012, at which time he stated that the back pain and sciatic neuralgia pain of the left leg had greatly diminished, and he had less pain and spasms of the upper dorsal and cervical spine and reported no headaches since last being seen. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on May 22, 2012, at which time he stated that the pain was more localized to the left sacroiliac and that he had some radiating pain into the left foot. He also described a slight increase of pain into the right side of the cervical spine with a mild dull headache. Petitioner was next seen on May 25, 2012, at which time he stated that he had a little soreness increased into the lower back over the weekend with more aggressive and strenuous activities. He also reported a slight increase of right-sided cervical pain. Petitioner was next seen on June 1, 2012, at which time he reported having a mild exacerbation stating that he had a mild case of bronchitis

causing coughing, and therefore straining, of the left lower back. He stated that the upper back and neck were doing much better. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on June 5, 2012, at which time he stated he was still making overall good progress with decreasing pain levels into the lower back and less sciatic neuralgia pain into the left lower extremity. He also described a slight increase of pain and discomfort into the right side of the neck into the right shoulder. Petitioner was next seen on June 8, 2012, at which time it was noted that he was still recovering from bronchitis and still coughing causing some strain into the muscles of the lower lumbar and lower dorsal. He still reported some mild pain into the right side of the upper back, neck and right shoulder. Petitioner was next seen on June 12, 2012, at which time he stated that he was still getting better and that even the upper back and neck had been much better the past week. Petitioner stated that he had returned to work and had some aggravation with work-related activities which he stated may be involving his work uniform, sitting for long periods of time and stress/anxiety. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on June 18, 2012, at which time he reported some mild back pain on the right side but reported a significant reduction of sciatic neuralgia symptoms. He also continued to express less pain into the upper back, neck and across the shoulders. Petitioner was next seen on June 25, 2012, at which time he complained of mild increased discomfort on the lumbar left lower back into the left hip/gluteal region. He also reported still little/no sciatic neuralgia pain and only mild soreness into the upper back on the right with little to no neck pain or headaches. Petitioner was seen on July 2, 2012, at which time it was noted that he stated that he had some increased back pain at the end of last week but that heat, some stretches and walking was able to relieve the pain. He had mild tightness into the muscles of the right upper shoulder around the right levator scapula and trapezius with little to no cervical pain and no headaches. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on July 9, 2012, at which time he reported that he was overall still making good progress and that he had been having some occasional upper back, neck and right shoulder pain but that the symptoms were much milder and less frequent than before. Petitioner was next seen on July 19, 2012, at which time it was noted that he had been having some intermittent pain along the lower back with some occasional paresthesias into the left leg to the knee, but the frequency of back and leg pain was much less. Petitioner reported mild soreness into the right side of the upper dorsal and cervical spine but this, too, was also much improved overall. Petitioner was next seen on August 1, 2012, at which time he stated that he had been doing some traveling and having a slight increase of lower back pain and discomfort. He had a slight increase of neck and shoulder pain on the right as well as a result of cleaning and housekeeping with mild headache. Petitioner was seen on August 15, 2012, at which time he reported a slight increase of back pain and left leg sciatic neuralgia discomfort. He also reported a slight increase of pain into the right side of the upper back, neck and right shoulder. (PX2).

Also included within the medical records were Authorizations for Absence taking Petitioner off work on May 22, 2012, May 4, 2012 and April 27, 2012. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on October 23, 2012, at which time he stated that overall he felt like he was still doing better until recently, stating that the intensity of his pain levels had been gradually getting worse. He stated that most recently the right-sided neck pain and radiating pain into the right shoulder/scapula with pain radiating into the right arm into the elbow had been getting worse. He was having post-traumatic and residual myofascial pain primarily of the dorsal and cervical muscles with also still some residual symptoms of lumbar intervertebral disk syndrome with lumbar radiculopathy/sciatic neuralgia as well as cervical radiculopathy and/or cervical brachial syndrome. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on March 21, 2013, at which time he stated that he had not been able to come in because of financial reasons, was still unemployed and apparently temporarily disabled from work-related activities. He stated that he had pain and burning discomfort from the lower back to the upper back, neck and across the shoulders with frequent headaches. He had bilateral upper extremity pain and pain into the left elbow, and had right elbow pain with numbness and tingling into the fingers. Petitioner's diagnosis was multilevel myofascial pain disorder complicated by prior trauma; lumbar and vertebral disc syndrome with sciatic neuralgia; lumbar and cervical spinal degenerative arthritis; cervicogenic headaches; and epicondylitis of the elbows. Petitioner was seen on March 26, 2013, at which time it was noted that his most aggressive pain continued to be the lumbar spine and left sacroiliac and left hip/gluteal. He also had right upper dorsal spasms/hypertonicity including muscles along the levator scapula, trapezius and cervical hypertonicity with joint pain into the mid and upper cervical spine bilaterally. Because of the impending litigation, financial concerns and lack of consistent employment, Petitioner could not commit to care. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on April 2, 2013, at which time he stated that he had been feeling a little bit better but the neck on the right side had been worse up until the last day. He stated that a few days ago he was having significant neck pain on the right with constant headaches. Petitioner was seen on April 16, 2013, at which time he stated that he had been having some increasing back pain recently with some sciatic neuralgia pain into the posterior left leg to the knee. He stated that the neck and shoulder pain had been slightly less and his headache pain was better. Petitioner was seen on April 23, 2013, at which time he reported that he had been feeling about the same. He continued to complain of a deep achiness along the lower back and hips as well as upper back and neck pain with some headaches. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on May 1, 2013, at which time it was noted that he stated that he had been doing a little bit better, and that after his last treatment he believed he had gained better mobility and overall less pain. He expressed less pain and discomfort into the lower back/hips as well as the upper back and neck. Petitioner had some right upper extremity neuralgia pain and still some occasional headaches from myofascial pain into the right levator scapula, trapezius and cervical paraspinal muscles. Petitioner was seen on May 8, 2013, at which time it was noted that he had more soreness after the last few days, and that he also complained of some increased paresthesias into the left leg to the knee. He stated that his neck pain had been slightly better overall with still the majority of the pain on the right side from the right upper dorsal into the lower and mid right cervical spine. He had radiating and referred symptoms into the right scapula and occasionally into the right upper arm. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on May 15, 2013, at which time he stated that he had been doing a little bit worse after working in the yard. He described more pain radiating from the left lower back into the left hip and gluteal region, and noted mild pain into the upper back, across the shoulders into the cervical spine. Petitioner was seen on May 21, 2013, at which time he stated that the pain into the left lower back had been slightly worse recently and that he expressed more sciatic neuralgia pain into the left leg to the knee. He also complained of pain into the left side of the neck radiating into the left shoulder/scapula, and felt an audible pop into the left side of the neck which had been painful ever since. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on May 30, 2013, at which time it was noted that he was doing a little bit better, stating that the low back pain had been slightly less. He stated that the pain into the upper back and neck had been moderate with some headaches. Petitioner was seen on June 11, 2013, at which time he presented with increasing symptoms of pain into the upper back and neck. He stated that his lower back was doing slightly better but periods of sitting and watching ballgames caused some soreness and stiffness into the neck and shoulders as well as some lower back pain. Petitioner was next seen on June 18, 2013, at which time he reported that the

low back pain and sciatic neuralgia pain had been slightly worse, and that his posture was slightly also worse with some antalgia leaning toward the right. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on June 25, 2013, at which time he stated that he had been able to get some relief of the lower back and left hip pain since the last treatment and that he had a therapeutic massage which was also helpful in reducing some of the pain and spasms. He stated that recently the pain had been slightly worse into the upper back, neck and across the shoulders. Petitioner was seen on July 1, 2013, at which time he stated that he had not been doing as well, that he had considerable time with less activity and periods of sitting and standing watching his son play ball. He reported increased spasms into the lumbar musculature with neuralgia pain bilaterally but slightly more aggressive into the left leg from the left behind the left knee. He had the most aggressive pain into the cervical/dorsal junction and again at the subocciptal and cervical spine at the C1level. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on July 18, 2013, at which time he stated that he was doing a little better and had been in the pool which had been helpful for reducing some of the tightness and pain/stiffness into the lower back, neck and shoulders. Petitioner was also seen on September 19, 2013, at which time he returned with multiple complaints. He stated that since he was last seen and treated his overall pain levels had been slightly better, but over the last couple of days he strained the right side of his lower back and currently had pain ranging from a dull ache to occasional sharp pain. He continued to have some upper back and neck pain that was bilateral as well as bilateral shoulder pain, and it was noted that he had less neuralgia-type symptoms into the upper as well as lower extremities. The diagnoses were noted to be: acute lumbar strain with myofascial pain/spasms; pre-existing lumbar intervertebral disc syndrome with facet joint dysfunction associated with facet arthropathy/hypertrophy; cervical and dorsal extensive myofascial pain disorder with cervical intervertebral disc syndrome; cervical degenerative arthritis; extensive rotator cuff syndrome bilaterally. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on September 24, 2013, at which time he stated that his lower back was feeling worse. He stated that the pain was now bilateral across the lumbar spine with increasing neuralgia symptoms into the left leg to the left foot. His noted secondary complaints included neck pain and soreness across the shoulders. He stated that the neck had been doing better and he had fewer headaches recently. Petitioner was next seen on October 2, 2013, at which time he stated that he had been doing about the same. He stated that he continued to have some left leg neuralgia pain that traveled just below and distal to the left knee. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was next seen on February 2, 2015, at which time Petitioner returned with the chief complaint of low back pain and secondary complaints of pain into the right side of the upper back and neck. He stated that the low back pain had been recently worse after returning to work. He stated that the pain had been chronic over the last few years but because of the length of time between treatments and returning to work, the pain had worsened. He described back pain as a constant deep ache with some occasional sharp radiating pains into the left leg, and the neck pain was a constant deep ache which was also more aggressive to the right side with some radiating pain into the shoulder/scapula and right upper arm to the elbow. The diagnoses were noted to be that of lumbar intervertebral disc syndrome with degenerative disc disease and facet joint arthropathy/hypertrophy contributing to hypomobility of the lumbar spine; lumbar radiculopathy/sciatica neuralgia as a result of some neural foraminal impingement; lumbar myofascial pain. (PX2).

The Whitehead Wellness Center records reflect that Petitioner was seen on February 4, 2015, at which time he stated that he was doing better. He stated that the pain and spasms into the left side of the lumbar spine had been slightly less and more comfortable since his treatment on Monday. He complained of mild/moderate pain from the right side of the neck into the right shoulder and scapula region.

Petitioner was next seen on February 20, 2015, at which time he stated that he was doing better. He stated that he had had less pain into the back on the left side, as well as less sciatic neuralgia pain into the left leg. He also reported that the pain and discomfort into the right side of the upper back and neck had still been consistent. Petitioner was also seen on March 9, 2015, at which time he stated that he was doing a little bit better. He stated that the pain levels of the left lower back had been much more tolerable and that he also had decreased sciatic neuralgia pain involving the left leg. It was noted that the chief area of complaint remained the right side of the upper back, neck and right shoulder. (PX2).

The medical records of The Orthopedic Center of St.Louis/Dr. Gornet were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on January 30, 2012, at which time it was noted that Petitioner had not been seen since March of 2011 at which time his neck was doing relatively well. Petitioner had gone back to work full duty. His main complaint was neck pain into his right trapezius, right shoulder, down his right arm to his forearm and hand. It was also noted that Petitioner had some mild low back pain to both buttocks and bilateral leg pain left greater than right. He stated that his problem currently began on September 26, 2011, when he was assisting a nurse with a patient with Lou Gehrig's Disease, the patient fell and he tried to bend forward to catch the patient and developed increasing pain. It was noted that Petitioner requested to see Dr. Gornet fairly immediately but this was his first available appointment. He had been off work since January 1, 2012 as he had expired his 90 days of light duty. He showed normal strength and sensation, and he had some mild guarding of the right shoulder. It was noted that Petitioner had a previous right shoulder problem in the past for which he had been referred to Dr. Paletta. An MRI was ordered but no further evaluation was approved. Dr. Gornet recommended a CT of the cervical spine, and he referred Petitioner back to Dr. Paletta to determine whether it was an aggravation of a pre-existing condition versus a new injury in the right shoulder. Dr. Gornet recommended physical therapy on Petitioner's neck and shoulders. It was noted that Petitioner understood that if the CT was negative from a cervical spine standpoint, Dr. Gornet would release him back to work full duty but this would pertain to his neck only, and that any shoulder issues would be at the prerogative of his treating physician. A work slip was issued on that date, allowing Petitioner to return to work light duty with restrictions of no lifting greater than 15 pounds. (PX3).

The records reflect that Petitioner returned to Dr. Gornet on April 5, 2012, at which time it was noted that Dr. Gornet had reviewed the CT scan and everything appeared to be stable. There was no evidence of any significant problems. Petitioner had been referred to Dr. Paletta who did not feel there was any issue of significance that would require surgical intervention, although it was noted that Dr. Paletta's notes were not available. Petitioner reported that he continued to have pain which affected his quality of life. He was released back to work full duty again, but it was noted that he felt he could not do his current job. Dr. Gornet did not see a strong physiologic basis to restrict him, as he had been working before with a C4-C7 fusion. Petitioner admitted that his symptoms were progressing to get worse before that and Dr. Gornet thought some of this may relate to his overall fusion and his concerns about going back to work. Petitioner was a maximum medical improvement. A return to work slip was issued on the same date, allowing Petitioner to return to work full duty with no restrictions. (PX3).

Included within Dr. Gornet's records was the interpretive report for a CT of the cervical spine performed on April 5, 2012 at CT Partners of Chesterfield. The impression of the interpreting radiologist was that of anterior decompression and instrumentation at the C3-4, C4-5, C5-6 and C6-7 levels, stable in appearance since the prior exam; disc replacement at C3-4 and interbody fusion changes C4 through C7 are stable; similar to the previous exam of over one year ago, there is minimal lucency across the interspace at C4-5, though no lucency adjacent to the interbody device or screws is observed. (PX3).

The medical records of The Orthopedic Center of St. Louis/Dr. Paletta were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner was seen on January 30, 2012, at which time Petitioner presented for evaluation of a new complaint of right shoulder pain. It was noted that Dr. Paletta had previously seen Petitioner for problems related to his left shoulder back in 2010, and that the MRI at

that time was unremarkable with no evidence of rotator cuff or labral pathology and that Petitioner had minimal AC joint arthritis. Dr. Paletta also saw him for problems related to the right shoulder in December 2010, at which time he had supraclavicular pain of his right shoulder of uncertain etiology. An MRI of the shoulder was recommended but not completed. Petitioner subsequently had some cervical issues and had been under the care of Dr. Gornet. Petitioner eventually had the MRI of the right shoulder done in August, but he was never provided with the results nor had he seen Petitioner or reviewed the MRI scan since the last visit in December 2010. (PX4).

The records reflect that it was noted that Petitioner had a new episode of injury on September 26, 2011. A nurse was helping transfer a patient with Lou Gehrig's Disease from the wheelchair to the bed, the patient started to fall, and Petitioner reached out to grab the patient to help stop him from falling. The patient was falling to the ground and Petitioner's arm was down in front of him, and he grabbed the patient with the arm extended down in front. Petitioner felt the pulling and pain in the right basicervical and shoulder region, and had increasing pain and discomfort since that time. Petitioner had been seen and evaluated by Dr. Gornet, and a recommendation was made for six weeks of therapy for the neck. He complained of tightness and pulling across the supraclavicular region and in the pectoral region of the right shoulder, things seemed to tighten up on him and he felt like his shoulders were being pulled inward. He also had some continuing neck complaints, and had persistent numbness and tingling down the arm as well. Dr. Paletta's impression was that of recurrent right shoulder pain of uncertain etiology. It was recommended that Petitioner undergo an ultrasound of the right shoulder, and if the ultrasound was negative and the rotator cuff was normal, then this was likely of cervical origin and he would recommend that Petitioner continue specifically under the care of Dr. Gornet. The Addendum noted that based on his clinical history and physical exam findings, it appeared that the majority of Petitioner's symptoms were cervical in origin, and it was unlikely that Petitioner had any significant shoulder pathology that would require primary treatment. Petitioner required no restrictions specifically to the shoulder. (PX4).

Included within Dr. Paletta's records was an Ultrasound Review dated February 9, 2012 which referenced a study completed at Barnes-Jewish Hospital on February 7, 2012. The Ultrasound Review noted that the ultrasound demonstrated evidence of tendinopathy of the supraspinatus and infraspinatus tendons without evidence of any significant partial thickness or full thickness rotator cuff tear; that no other abnormalities were noted; that the biceps tendon was noted within the bicipital groove; that there was minimal fluid in the peritendon sheath; and that no subdeltoid bursitis was noted. The impression was noted to be no evidence of significant rotator cuff pathology or other structural abnormality. Dr. Paletta noted that the majority of Petitioner's symptoms were cervical in origin, and that Petitioner was at maximum medical improvement with respect to any shoulder issues. It was further noted that ongoing treatment should be directed at the neck, and that any additional recommendations for treatment and/or restrictions were as per Dr. Gornet. (PX4).

The medical records of HR Physical Therapy were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The Initial Evaluation was performed on February 2, 2012, at which time it was noted that Petitioner had the van door shut on his head about five weeks after having a fusion that resulted in a second surgery in March 2009. Petitioner's shoulders felt weak since the second surgery, but he re-injured his right shoulder at work while helping the nurse transfer an inmate. The referring physician was noted to be Dr. Gornet. Petitioner stated that the tightness sometimes caused a headache and the sensation to vomit, and that he had vomited on two occasions. He also stated that he was seeing Dr. Paletta for his right shoulder. Petitioner reported that his neck pain was in the front and felt very tight, and he got occasional numbness and tingling into the lateral two fingers of both hands. His right shoulder pain increased with movement, elevation at shoulder level or higher and hanging the arm down. He had pain in the shoulder blade, posterior and anterior shoulder, as well as down the arm to the bicep and forearm. Petitioner underwent physical therapy for the timeframe of February 2, 2012 through April 4, 2012. (PX5).

The report for an Extremity Sonography performed at Barnes-Jewish Hospital on February 7, 2012 was entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The report pertained to a right shoulder sonogram, the impression of which was that of tendinopathy of the supraspinatus and infraspinatus, no evidence of a rotator cuff tear. (PX6).

The Diagnostic Imaging Report for an MRI of the right shoulder performed on January 9, 2015 at Herrin Hospital with a Reason for Admission of chronic neck pain and right shoulder arthralgia was entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The History noted was that of right shoulder pain, arthralgia. The impression of the interpreting radiologist was that of: (1) AC joint minor arthritis; lateral acromial downsloping predisposes patient to rotator cuff injury; (2) tiny, benign humeral head cyst – may be due to impingement; (3) superior labrum degenerative change vs. partial thickness tear; (4) supraspinatus and subscapularis mild tendinopathy, no rotator cuff tear. (PX7).

The Diagnostic Imaging Report for an MRI of the cervical spine performed on January 9, 2015 at Herrin Hospital with a Reason for Admission of chronic neck pain and right shoulder arthralgia was entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The History noted was that of chronic neck pain and right shoulder pain. The impression of the interpreting radiologist was that of: (1) S/P ACDF at C3-C4-C5-C6-C7; (2) no c-spine central canal stenosis; (3) multilevel foraminal narrowing (especially left C3-4); (4) benign hemangioma in the T2 body; (5) ethmoid and right maxillary sinusitis. (PX8).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 9.

The medical records of Mark Whitehead, D.C. were entered into evidence at the time of arbitration as Respondent's Exhibit 1. Petitioner was seen on December 3, 2010, at which time he presented with multiple complaints ranging from upper back and neck pain and bilateral shoulder pain as well as lower back pain with radiating pain intermittently into the posterior left leg, midway between hip and knee. He also expressed some occasional radiating and referred symptoms of the upper extremities primarily from the elbows inferiorly into the hands. Petitioner had undergone a cervical spine fusion at C4-C7 by Dr. Park in August of 2008, he returned to work in January 2009 and was struck in the head at work herniating the C3/C4 disc for which he underwent disc replacement by Dr. Gornet in July 2009. Petitioner had not returned to work and continued to have pain and discomfort of the upper back, neck and shoulders, and it was further noted that he reported bilateral shoulder pain and was seen by Dr. Paletta and diagnosed as having osteoarthritis of the left shoulder and was scheduled to see him the following week for a right shoulder examination. Petitioner's preliminary diagnosis was post-traumatic/post-surgical myofascial pain disorder of the cervical and dorsal spine as well as rotator cuffs bilaterally, and the origin of his pain was primarily connective tissue as well as post-surgical myofascial changes. Dr. Whitehead further noted that he suspected that some discomfort may be psychogenic from depression which was from the extensive surgical procedures, loss of gainful employment and pain that had endured over the last two years. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on December 7, 2010 for treatment of the pain of the upper back, neck and shoulders. His symptoms and subjective complaints remained consistent with the week prior. Petitioner was seen on December 10, 2010, at which time it was noted that he stated that he had some soreness of the upper back and shoulders after his last treatment with overall pain levels being about the same. Petitioner was also seen on December 14, 2010, at which time he reported that he had some time of decreased pain into the upper back, neck and shoulders, stating that the last couple of days had felt better with increased mobility. He still reported a mild to moderate pain when getting dressed, such as putting a shirt and coat on, with reaching above head and behind. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on December 17, 2010, at which time he reported that his overall range of motion was doing better into both upper extremities. He stated that the pain levels were still mostly moderate of the upper back right side of the neck and across the shoulders. He also complained of pain into the upper arms radiating from the shoulders into the elbows. Petitioner was seen on December 20, 2010, at which time he reported still having improvement with improved range of motion and mobility of the upper back, neck and shoulders, but he continued to complain of increasing pain further distally from the shoulders to the elbows. Petitioner was also seen on December 22, 2010, at which time it was noted that he reported continued improvement of the upper back, neck, and shoulders with improved mobility and range of motion. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on December 27, 2010, at which time he reported he was still making good progress with improved mobility of the upper back and shoulders. He still complained of moderate to significant pain into the lower right cervical spine and was seemingly worse with right arm abduction. He stated that it felt like something was pinched between the neck and shoulder, and it was noted that Dr. Whitehead suspected that the area of pain had something to do with the surgical implant of his neck. Petitioner was seen on December 29, 2010, at which time he stated that the pain levels and ranges of motion of the upper back, neck and shoulders and upper extremities were much better. He stated that the last two days were the best that he had felt in several months, and that he had considerable relief into the lower right cervical spine. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on January 3, 2011, at which time he reported a mild exacerbation of right-sided neck pain and shoulder pain over the weekend helping another person lift a boat into the back of a truck. He stated that the pain was more localized to the right side with palpation findings confirming a slight increase in spasms into lower right cervical muscles with increased joint pain and tenderness into the right cervical/dorsal junction and slight increase in pain and limited mobility into the right shoulder/glenohumeral. Petitioner was seen on January 12, 2011, at which time he stated that the left shoulder and arm were doing much better with a slight increase in discomfort into the right shoulder with a slight increase in pain on right shoulder abduction with pain still along the lower right cervical spine. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on January 14, 2011, at which time he reported that his right arm and shoulder had been slightly better since he was last treated. He continued to report excellent progress with the left upper back, shoulder and arm. He reported some mild to slightly moderate and intermittent pain into the right cervical/dorsal junction. Petitioner was seen on January 7, 2011, at which time it was noted that he reported that he continued to make good progress with significant reduction of back and neck pain. He stated that he had been having a slight increase in right shoulder and arm pain, pointing to the area along the lateral right elbow and just superior into the bicep muscle. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on January 17, 2011, at which time he reported he had been a little better since he last treated and reported that the pain levels of the right upper extremity, including right side cervical spine, right shoulder, arm and elbow had all felt slightly better. Petitioner was seen on January 21, 2010 [*sic*], at which time he reported a slight increase of symptoms of upper back and neck pain. He reported no specific onset but felt that he had more muscle tightness into the muscles between the shoulders and lower right side of the cervical spine. Petitioner was also seen on January 24, 2011, at which time he reported that for unknown reasons he had increased right arm pain over the weekend. He also expressed that he had more pain and continued to have intermittent pain into the right lower cervical spine. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on January 28, 2011, at which time he reported that he continued to have some intermittent pain into the lower right cervical, right upper dorsal and right shoulder, but overall pain levels were still considerably decreased and overall ranges of

motion and mobility were much better from before. Petitioner was also seen on February 1, 2011, at which time he presented with a chief complaint of lower back pain and pain and burning into the left leg. Petitioner was also seen on February 4, 2011, at which time he reported that he had a good week with pain decreasing into the right upper back, neck and right shoulder with overall better shoulder and right upper extremity range of motion. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on February 8, 2011, at which time he complained of increasing lower back pain and soreness as well as a continued improvement into the right upper back, right shoulder and cervical spine. Petitioner was seen on February 11, 2011, at which time he stated that the pain and sciatic discomfort had both been better. He also continued to express gradual but continued improvement into the right upper back, neck and right shoulder. Petitioner was also seen on February 15, 2011, at which time he stated that he was still making good progress, especially of the upper back, neck and right shoulder. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on February 18, 2011, at which time he stated that he was still making good progress and had a significant reduction of upper back, neck, right shoulder and right upper extremity pain. At the time of Petitioner's February 21, 2011 visit, he stated that he was feeling much better overall, was able to play basketball with his son and stated that he had some soreness into the upper back and shoulders. His overall progress continued to make substantial strides, especially of the upper back, neck and shoulders. When Petitioner was seen on February 28, 2011, he stated that he was not doing as well as he had attempted to do some walking for two hours the week prior as well as some gentle riding on a 4-wheeler. He stated later that night he had increasing back pain with increased left leg sciatic neuralgia pain, especially worse into the left knee. He reported that the right upper back, neck and right shoulder had been doing about the same, which was still overall better and slightly improving. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on March 21, 2011, at which time he stated that he had some difficulty with right arm and shoulder discomfort the week prior after fishing but stated that the pain had gradually and significantly improved. He still had some intermittent pain of the right shoulder and lower right cervical and lower lumbar spine, but his overall pain levels were still significantly reduced compared to several weeks/months ago. At the time of the March 28, 2011 visit, Petitioner stated that he did some turkey hunting over the weekend and stated that he had significant pain Saturday evening and Sunday. He described it as increased muscle spasms across the lower lumbar/lumbar spine with some radicular symptoms into the lower extremities. He also reported a slight increase in soreness across the shoulders into the cervical spine but the upper back/dorsal and cervical spines were still much improved overall. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on March 31, 2011, at which time he reported some mild pain and discomfort across the mid and upper back/across the shoulders and cervical spine. He also complained of some restricted mobility of the right shoulder and also mild headache. As of the April 4, 2011 visit, Petitioner reported a mild to moderate amount of pain into the mid and upper back, neck and right shoulder. He had restricted mobility slightly increased into the right shoulder with shoulder abduction and external rotation. As of the April 7, 2011 visit, Petitioner reported that his lower back had been feeling better but his upper back, neck and right shoulder pain had remained painful and possibly slightly worse overall. He reported increased restricted mobility from the right side of cervical spine into the right shoulder/scapula and some radiating and referred pain into the right arm to the elbow. (RX1).

The Mark Whitehead, D.C. records reflect that as of the April 14, 2011 visit, Petitioner expressed less pain of the upper back and neck and better cervical and right shoulder joint mobility. He stated that the neck and right shoulder were slightly more uncomfortable on that date compared to the lumbar spine. At the time of the April 21, 2011 visit, Petitioner's chief complaint was the right upper extremity/shoulder

with Petitioner pointing to pain along the lower right cervical/upper trapezius muscle region. He reported pain with abduction of the right arm and right cervical rotation with lateral flexion and extension to the right. At the time of the May 9, 2011 visit, Petitioner reported that the pain levels into the left side of the neck had been slightly worse over the last couple of days. He reported that the pain levels into the back and lower extremities had also been better lately, and that the right upper extremity pain was still frequent with pain on the lower right cervical/right upper dorsal and occasional pain into the right rotator cuff as well as into the right arm distally to the elbow. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on May 13, 2011, at which time he reported less pain and spasms of the lower lumbar/LS level and also reported less pain and discomfort into the left side of the neck with improved cervical joint range of motion/mobility. He had myofascial pain along the lower right cervical down toward the right levator scapula and trapezius muscles and some hypertonicity with pain and tenderness along the distal bicipital tendon. As of the June 20, 2011 visit, Petitioner returned with multiple complaints of lower back/hip pain and upper back and neck pain and right upper extremity discomfort. He stated that overall over the last several weeks he had been feeling better and stated that his symptoms were starting to slightly worsen once again. His pain and discomfort primarily on the right side in the cervical and upper dorsal region was one of the areas of chief complaint. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on June 24, 2011, at which time he reported mild soreness across the lower back and moderate soreness into the muscles of the upper back with Petitioner pointing to the upper trapezius and cervical on the posterior and lateral scalenes as well as anterior cervical flexor muscles. Petitioner was also seen on July 18, 2011, at which time he presented with low back pain and muscle hypertonicity noted in the cervical and lumbar regions. At the time of Petitioner's July 22, 2011 visit, he reported his low back pain was improving but his neck and right shoulder pain persisted. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner was seen on July 25, 2011, at which time he described less pain into the right side of the cervical and dorsal spine. He reported less radiating symptoms overall into the lower extremities as well as the right upper extremity since last week's treatments. He continued to have pain in the right shoulder girdle region which had been consistent over the last several months. The area of complaint was along the extreme lower inferior aspect of the right cervical spine into the region around the first rib just posterior to the clavicle/supraclavicular fossa. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner next was seen on August 3, 2011, at which time it was noted that he continued to have the intermittent pain that was still frequent at times involving the right sided lower cervical/supraclavicular region extending into the right shoulder and right upper arm. He reported spasms with head and cervical rotation from side to side as well as looking up/looking down. He still pointed to the lower right cervical region/upper trapezius as the area of chief complaint with palpation findings noting deep pain and joint tenderness into the region of the T1/first rib and supraclavicular region. There was still pain on the anterior right shoulder joint along with the subacromial with still some tendinosis of the supraspinatus and more milder into the bicipital tendon. Petitioner was originally scheduled for an MRI of the right shoulder/shoulder girdle in the summer of 2010 but the MRI was never performed, but he had been rescheduled to the following week. He reported that the lower back pain and lower extremity discomfort had been milder lately and that the majority of his pain had been into the right-sided cervical, upper dorsal and right shoulder. He continued to have pain into the lower cervical and supraclavicular region as well as more achiness into the anterior/posterior right shoulder. (RX1).

The Mark Whitehead, D.C. records reflect that an MRI was obtained on August 8, 2011, which purportedly noted tendinopathy of the supraspinatus and infraspinatus with a small articular surface tear

noted; tendinopathy was also found of the subscapular with some fluid into the subcoracoid bursa. The records reflect that he explained that the increase in symptoms of pain of the right shoulder was likely inflammatory but he still had concerns of pain into the lower cervical spine. Dr. Whitehead believed that some of the pain was likely mechanical as a result of hypermobility into the cervical/dorsal junction secondary to cervical spinal fusion surgery of the superior segments. He recommended that Petitioner be referred back to Dr. Paletta. (RX1).

The Mark Whitehead, D.C. records reflect that Petitioner started treating at this facility back in January of 1995, at which time he reported lower and upper back pain. He reported issues with his upper back and neck on the right side as far back as November 2003. He was involved in a motor vehicle accident in December 2004, at which time he complained of upper back and neck pain. He stated that he felt he had reached maximum medical improvement as of July 8, 2005. (RX1).

The IME report of Dr. James Emanuel was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The IME report indicated that Petitioner's past medical history was very complicated, and included complaints of neck pain dating back to 2008. Petitioner had a non-work related complaint of neck pain and underwent surgery for multi-level fusion in the cervical spine, after which he reported he never was really doing very well following surgery. He reported wanting to get back to work following the cervical spine surgery because he needed the money. He worked for approximately five months following the cervical spine surgery and apparently was slammed in the head by a van door as he was going home from work; it struck him on the right side and forced his head to the left. He reported worsening neck pain and shoulder pain at that time. (RX2).

The IME report indicated that Petitioner reported that he did not do well following the surgery by Dr. Gornet in August 2010 and complained of shoulder pain, and that a referral was made to Dr. Paletta. Petitioner indicated that it was his understanding that Dr. Paletta felt most of his shoulder pain was related to his neck. Petitioner indicated that an MRI of the left shoulder was ordered by Dr. Paletta and he considered giving him an MRI of the right shoulder but it was not done at that time. Petitioner was then involved in a second injury on September 26, 2011, at which time he had been working in the medical unit. Petitioner stated that an inmate with Lou Gehrig's Disease was falling out of his wheelchair and he reached to grab the patient, which occurred at 12:30 a.m. At 5:30 a.m., the same patient was being cared for by a unit nurse assisting him out of his wheelchair, at which time the patient tripped and Petitioner grabbed the patient by the midsection to lift him into bed. He reported that within a half hour he had difficulty lifting his shoulder away from his body. He indicated that another inmate had hung himself that night and that he was responsible to lift the body but had to request assistance because he was unable to lift with his right arm. He reported the injury and was seen by the nurse, who then referred him back to Dr. Gornet who then sent him to Dr. Paletta. (RX2).

The IME report indicated that Dr. Gornet performed an ultrasound and recommended an MRI, which was denied. Petitioner reported obtaining an MRI from his chiropractor. Petitioner indicated that prior to 2008 he had no complaints of shoulder pain, but Petitioner then admitted that he felt his shoulder pain in 2008 was coming from his neck because he noticed it when he would put his head and neck into a certain position. Petitioner felt he injured his right shoulder as a result of the September 26, 2011 injury and denied any previous complaints of shoulder pain. He reported current complaints of headaches, blurred vision, pain on both sides of his neck both front and back, pain on top of his shoulder and pain radiating to the biceps and down into the forearm. He indicated that both of his hands go to sleep, right worse than left, and that he has pain holding a soda and cramping in the right hand when he attempted to hold any weight. He also complained of pain between the bilateral shoulder blades, as well as difficulty with his low back. (RX2).

The IME report indicated that Dr. Emanuel's diagnoses were that of acromioclavicular joint arthritis, rotator cuff tendinopathy, possible partial thickness rotator cuff tear supraspinatus tendon and

mild subacromial bursitis. Dr. Emanuel indicated that in his opinion Petitioner's current diagnosis was not related to the alleged injury of September 26, 2011, and that he believed the condition was degenerative in nature. He indicated that the medical records indicated that Petitioner had complaints of right shoulder pain prior to the September 26, 2011 injury with laying directly on the shoulder and pulling clothes on/off, and that these symptoms were suggestive of a symptomatic acromioclavicular joint. He indicated that he did not believe Petitioner injured either his right or left shoulder as a result of the injury where his head was slammed by a van door, and he believed that the symptoms referable to the shoulders at that time were referred from Petitioner's neck. He indicated that he believed Petitioner had reached maximum medical improvement with regard to his condition, and that the date of maximum medical improvement was that of February 9, 2012 which was also the date that Dr. Paletta placed Petitioner at maximum medical improvement. He indicated that he believed Petitioner could return to work within the medium physical demand level outlined by the FCE. (RX2).

The evidence deposition of Dr. James Emanuel was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Emanuel testified that he is board-certified in orthopedic surgery, that he did a sports medicine fellowship, and that his practice is primarily shoulder surgery. He testified that he performs approximately four independent medical evaluations per week. He performed an examination of Petitioner on October 18, 2012. (RX3).

Dr. Emanuel testified that Petitioner made complaints related to his right shoulder at the time of the examination. He testified that the examination took approximately 10 minutes, and it consisted of observing Petitioner's shoulder without his shirt on, going through range of motion and testing the strength and stability of Petitioner's shoulder. He testified that Petitioner had evidence of some thickening of the AC joint on both of his shoulders, the right slightly worse than the left, and that this was indicative of probably arthritic changes at the AC joint. He testified that Petitioner demonstrated some tenderness in the front portion of the shoulder on the right but not on the left, and that he had full range of motion of his shoulder, both actively and passively, and demonstrated excellent rotator cuff strength of both shoulders. He testified that Petitioner showed a positive Speed's test on the right shoulder, which was used to test the biceps tendon or the anterior portion of the rotator cuff, and that Petitioner's Yergason test was negative which meant it was most likely not his biceps tendon but probably more irritation in the area of the rotator cuff. He testified that Petitioner had a positive crossover exam which tested the AC joint, and that the test was usually positive in patients that have arthritis of the AC joint. Petitioner showed no signs of bursitis or impingement, and he had no crepitus or grinding in his shoulder. (RX3).

Dr. Emanuel testified that he performed an x-ray of Petitioner's right shoulder, which showed some very early arthritic changes of the AC joint but was otherwise normal. He testified that this was corroborated by the physical examination. Dr. Emanuel testified that he took a history from Petitioner at the time that his physical examination was performed, which included a prior history of neck injury, neck surgery and prior evaluation of both shoulders by Dr. Paletta that preceded the date of injury. He testified that he also reviewed voluminous medical records, the findings of which he summarized within his IME report. Dr. Emanuel testified that his assessment was that of AC joint arthritis of the right shoulder with some tendinopathy of the rotator cuff, possible partial thickness tear of the supraspinatus tendon with some mild subacromial bursitis. (RX3).

Dr. Emanuel testified that after his interview with Petitioner and his review of the medical records, he thought there was evidence that Petitioner had complaints of right shoulder discomfort that predated the September 26, 2011 injury which included symptoms of discomfort laying on his shoulder at night and pulling his clothes on and off, which he had reported to Dr. Paletta. He testified that these were symptoms that people with arthritic changes at the AC joint oftentimes report, and he felt that the majority of Petitioner's complaints were more degenerative in nature than they were from an acute traumatic event.

He testified that he believed that Petitioner's condition was unrelated to his work activities, specifically the work injury of September 26, 2011. (RX3).

On cross-examination, Dr. Emanuel testified that the possible partial thickness tear of the supraspinatus tendon diagnosis was based on his interpretation of the MRI films from August 8, 2011. He agreed that prior to the incident of September 26, 2011, Petitioner had been able to perform the aspects of his job, and that the complaints for the right shoulder before the accident had to do with laying directly on his shoulder and pulling clothes off and on. He testified that Petitioner did not voice any complaints to him about the ability or inability to do his job prior to September 26, 2011. Dr. Emanuel testified that in his history, Petitioner did not tell him whether he was taken off work after the accident for the shoulder but he believed that Dr. Paletta had seen him after the injury and it was his understanding that he put Petitioner back to work for both of his shoulders full duty without restrictions. (RX3).

On cross-examination, Dr. Emanuel testified that he did not review the medical records of Dr. Smith. He agreed that Petitioner related to him that the symptoms in his shoulder became worse after the accident of September 26, 2011, and that by Petitioner's history, his symptoms at least became worse after the accident. When asked if the accident of September 26, 2011 might or could have been an aggravation of the pre-existing condition in the shoulder, Dr. Emanuel testified that this would be based on history alone and that Dr. Paletta – who saw the patient at the closest to the time of injury – did not feel that way but rather felt that Petitioner's symptoms did not match up to the objective findings and could not be related to the work injury. He testified that he believed that Petitioner's symptoms were related to the shoulder rather than the neck, and that the ultrasound that was performed was a very solid test for the rotator cuff and had high sensitivity and specificity as with an MRI scan. He agreed that by history, the symptoms Petitioner had prior to September 26th were not bad enough to keep Petitioner from being able to work. (RX3).

A copy of the Settlement Contract Lump Sum Petition and Order for Case 10 WC 5242 pertaining to a July 4, 2009 incident was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The contract referenced an accident involving a van door slamming on Petitioner's head and neck, which was settled for 25% loss of use of the man as a whole. The contract was approved on November 27, 2012. (RX4).

The Workers' Compensation Documentation Log was entered into evidence at the time of arbitration as Respondent's Exhibit 5. The Illinois Form 45 was prepared on September 29, 2011 and referenced a date and time of accident of September 26, 2011 at 5:00. The Form indicated that Petitioner was helping a nurse with a handicapped inmate who fell getting out of a wheelchair, injuring his right shoulder. The Workers' Compensation Employee's Notice of Injury indicated that Petitioner's date of injury or illness was September 26, 2011 at 12:30 and 5:00 a.m., and that he reported it to his supervisor on September 29, 2011. When asked to explain why not reported on the date of incident, Petitioner indicated "Already had excisting [*sic*], knew it hurt when did it didn't know how bad, know pain is severe." Petitioner signed the document on September 29, 2011. The Initial Workers' Compensation Medical Report signed by Dr. Smith on September 29, 2011 allowed Petitioner to return to work as of September 29, 2011 with restrictions of no prisoner contact and no use of the right arm above chest level. The Supervisor's Report of Injury or Illness dated October 3, 2011 referenced a date of accident/incident of September 26, 2011 at 12:30 and 5:00 a.m. and indicated that notice was received orally on October 1, 2011 at 11:00 p.m. A Demands of the Job pertaining to Petitioner's position as a Correctional Officer was prepared on October 3, 2011. (RX5).

A letter dated November 19, 2012 from CMS directed to Petitioner's attorney was entered into evidence at the time of arbitration as Respondent's Exhibit 6. The letter indicated that a determination had been made by CMS that Petitioner's claim was not compensable. (RX6).

A letter dated November 19, 2012 from CMS directed to Petitioner's attorney was entered into evidence at the time of arbitration as Respondent's Exhibit 7. The letter indicated that Dr. Emanuel's opinion was that Petitioner's current diagnosis regarding the right shoulder was not related to the injury on September 26, 2011 and that Petitioner had reached maximum medical improvement on February 9, 2012 and, as a result thereof, temporary total disability would be suspended effective November 19, 2012. (RX7).

The Temporary Total Disability payout was entered into evidence at the time of arbitration as Respondent's Exhibit 8. (RX8).

The Orthopedic Center of St. Louis records were entered into evidence at the time of arbitration as Respondent's Exhibit 9. Petitioner was seen on December 6, 2010 at which time he presented for a chief complaint of right shoulder pain. He had mentioned to Dr. Paletta at the time of his evaluation of the left shoulder that he had a previous history of right shoulder issues, but it was not really bothering him at that time. He stated that soon after he saw Dr. Paletta, he started having some increasing right shoulder complaints that he related to putting on and taking off his shirt and to sleeping on the shoulder. He currently complained of pain mainly confined to the supraclavicular region, and did not really complain of pain in the shoulder joint at all. He was very non-specific about how it bothered him and how it really started. He denied any radiating pain or associated numbness, tingling or paresthesias. Dr. Paletta's impression was that of right shoulder supraclavicular pain of uncertain etiology, and it was noted that his symptoms were very vague and his physical findings were minimal at that point. He did not think there was any significant primary pathology of the shoulder, but did recommend that Petitioner undergo an MRI. If the MRI was completely normal then there was nothing to offer and he would recommend that Petitioner return to full duty as tolerated. (RX9).

A photo that was printed on April 2, 2013 showing Petitioner wearing hunting gear and holding the head of a deer was entered into evidence at the time of arbitration as Respondent's Exhibit 10.

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on September 26, 2011, Petitioner sustained an accident that arose out of and in the course of his employment with Respondent.

With respect to disputed issue (F) pertaining to causal connection, the Arbitrator finds that Petitioner has failed to prove that his current condition of ill-being is causally related to the accident of September 26, 2011, and that Petitioner has proven by a preponderance of the evidence that he sustained a temporary exacerbation of a pre-existing condition in his right shoulder during the timeframe of September 26, 2011 through February 9, 2012.

At the outset, the Arbitrator finds Petitioner's credibility to be suspect given his testimony at the time of arbitration. Specifically, the Arbitrator points out that Petitioner testified that he had no issues with his right shoulder prior to the accident of September 26, 2011 since he had returned to work after his prior work-related neck claim, but the medical records from Mark Whitehead, D.C. clearly indicate otherwise. The pre-accident medical records of Dr. Whitehead reflect that Petitioner complained of issues involving the right shoulder/arm and neck regions consistently throughout the entire timeframe of January 7, 2011 through August 8, 2011, and that Petitioner had treated within mere weeks of the September 26, 2011 accident with nearly identical complaints of pain as compared to those made after the accident at issue. The Arbitrator notes that out of the 30 different chiropractic visits during the timeframe of January 7, 2011 through August 8, 2011, on only two occasions was no reference made to any complaints involving the right shoulder/arm and neck regions. The Arbitrator also notes that when Petitioner saw Dr.

Emanuel he denied any previous complaints of shoulder pain, which is wholly contrary to the complaints consistently noted in the pre-accident medical records of Dr. Whitehead as well as the prior treatment records with Dr. Paletta. (RX2; RX3; RX9). That said, the Arbitrator questions the veracity of Petitioner's testimony on this issue.

The Arbitrator places greater reliance upon the opinions of both Dr. George Paletta, one of Petitioner's treating physicians, and Dr. Emanuel, the IME physician, in this matter. The Arbitrator notes that Dr. Paletta's impression as of the time of the January 30, 2012 office visit was that of recurrent right shoulder pain of uncertain etiology. He noted that the majority of Petitioner's symptoms were likely cervical in origin but, given the new incident that occurred in September and his increasing pain since that time, he recommended that Petitioner undergo an ultrasound of the right shoulder. He indicated that if the ultrasound was negative and the rotator cuff was normal, then this was likely of cervical origin and he would recommend that Petitioner continue specifically under the care of Dr. Gornet. The Addendum noted that based on Petitioner's clinical history and physical exam findings, it appeared that the majority of his symptoms were cervical in origin, and it was unlikely that Petitioner had any significant shoulder pathology that would require primary treatment. Dr. Paletta noted that Petitioner required no restrictions specifically to the shoulder. (PX4). The Arbitrator notes that even Dr. Gornet, who was Petitioner's treating physician for the prior accident on July 4, 2009 (which was settled on contracts for the 10 WC 5242 claim), gave Petitioner a full duty release at the time of the April 5, 2012 visit, which was also the time at which he suggested that Petitioner had attained maximum medical improvement and made no recommendation for additional treatment for Petitioner's cervical condition. (RX4; PX3).

Furthermore, Dr. Emanuel in his IME report and evidence deposition indicated that although he did not believe that Petitioner's current diagnosis was related to the September 26, 2011 accident and that Petitioner's condition was degenerative in nature, he agreed with Dr. Paletta that Petitioner had attained maximum medical improvement as of February 9, 2012. (RX2; RX3). As such, the Arbitrator finds that Petitioner has proven by a preponderance of the evidence that he sustained a temporary exacerbation of a pre-existing condition that, in accordance with the opinions of Dr. Paletta and Dr. Emanuel, had reached maximum medical improvement as of February 9, 2012, and that Petitioner's condition of ill-being subsequent to that date is not causally related to the accident of September 26, 2011.

With respect to disputed issue (J) pertaining to medical services, the Arbitrator finds that Respondent is responsible for payment of the medical treatment incurred during the timeframe of September 26, 2011 through February 9, 2012 under Sections 8(a) and 8.2 of the Act, and that Respondent is not responsible for payment of any medical treatment received subsequent to February 9, 2012 in reliance upon the opinions of both Dr. Paletta and Dr. Emanuel that Petitioner had reached maximum medical improvement as of February 9, 2012. The Arbitrator further finds that Respondent is also responsible for reimbursement to Petitioner for all out-of-pocket expenses as reflected in PX9 related to medical treatment rendered during the timeframe of September 26, 2011 through February 9, 2012 as well. The Arbitrator notes that the parties stipulated at the time of arbitration that Respondent was entitled to a credit in the amount of $5,628.82 for medical bills paid through its group medical plan under Section 8(j) of the Act. (AX1).

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator finds that, pursuant to the agreement of the parties at the time of arbitration, Petitioner is entitled to temporary total disability benefits for the timeframe of January 10, 2012 through December 5, 2012. The Arbitrator further finds that Petitioner is not entitled to temporary total disability benefits for the timeframe of December 6, 2012 through February 14, 2015 as requested by Petitioner at the time of arbitration.

The Arbitrator notes that Dr. Paletta in the February 9, 2012 office note indicated that Petitioner required no restrictions specifically to the shoulder. (PX4). The Arbitrator further notes that Dr. Gornet gave Petitioner a full duty release at the time of the April 5, 2012 visit. (PX3). While Petitioner testified that between 2012 and February of 2015 he remained on light duty at the request of Dr. Smith, the Arbitrator notes that Dr. Smith ordered the FCE at the request of Petitioner's attorney on April 6, 2012, which was the day after Petitioner received his full duty release from Dr. Gornet. The Arbitrator further notes that no work restriction slips and/or off-work slips were entered into evidence at the time of arbitration beyond the September 26, 2011 Work Release from Logan Primary Care and the Authorizations for Absence from Dr. Whitehead for the dates of May 22, 2012, May 4, 2012 and April 27, 2012. (PX1; PX2). That said, the Arbitrator finds that, pursuant to the agreement of the parties at the time of arbitration, Petitioner is entitled to temporary total disability benefits for the timeframe of January 10, 2012 through December 5, 2012 only, and that Petitioner is not entitled to temporary total disability benefits for the timeframe of December 6, 2012 through February 14, 2015. Related thereto, the Arbitrator notes that the parties stipulated at the time of arbitration that Respondent is entitled to a credit of $25,262.87 for temporary total disability benefits already paid. (AX1).

With respect to disputed issue (L) pertaining to nature and extent, the Arbitrator makes no conclusions of law as this issue is rendered moot because of the Arbitrator's conclusions in regard to disputed issue (F).

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

Amy Renea Beard,

Petitioner,

17IWCC0496

vs.

NO: 14 WC 11749

SOI/Murray Developmental Center,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 28, 2016, 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.

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

17IWCC0496

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 16 2017
o8/3/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

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

17IWCC0496

BEARD, AMY RENEA
Employee/Petitioner

Case# **14WC011749**

SOI/MURRAY DEVELOPMENTAL CENTER
Employer/Respondent

On 11/28/2016, 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 0.60% 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 RICH RICH & COOKSEY PC
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CERTIFIED as a true and correct copy
pursuant to 820 ILCS 305/14

NOV 28 2016

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

17IWCC0496

STATE OF ILLINOIS)
)SS.
COUNTY OF Williamson)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Amy Renea Beard
Employee/Petitioner

v.

State of Illinois/Murray Developmental Center
Employer/Respondent

Case # **14** WC **11749**

Consolidated cases: **N/A**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Nancy Lindsay**, Arbitrator of the Commission, in the city of **Herrin**, on **September 9, 2015** and in the city of **Springfield** on **August 22, 2016** and in the city of **Urbana** on **September 21, 2016**. 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 **February 18, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$39,501.67**; the average weekly wage was **$759.65**.

On the date of accident, Petitioner was **37** years of age, ***single*** with **3** 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 **$2,170.54** for TTD, $0 for TPD, $0 for maintenance, and a general credit for any non-occupational disability benefits paid to Petitioner on account of her injury.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$37,117.14**, pursuant to the medical fee schedule or a PPO agreement (whichever is less) as provided in § 8(a) and § 8.2 of the Act. Respondent shall be given credit for medical benefits that have been paid through its group carrier, 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 § 8(j) of the Act.

Respondent shall authorize and pay for the surgical treatment recommended by Dr. Raskas if still deemed appropriate.

Respondent shall pay Petitioner temporary total disability benefits of **$506.43/week** for **27 1/7 weeks**, commencing **March 3, 2015**, through **September 9, 2015**, as provided in § 8(b) of the Act.

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

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

Nancy Lindsay
Signature of Arbitrator

November 19, 2016
Date

NOV 28 2016

Amy Renea Beard v. State of Illinois/Murray Developmental Center, 14 WC 11749 (19(b))

FINDINGS OF FACT and CONCLUSIONS OF LAW

The Arbitrator finds:

Petitioner worked for Respondent on 2.13.14 from 5:10 a.m. to 4:00 p.m. (receiving 2.5 hours of overtime paid in cash. (RX 8)

Petitioner worked for Respondent on 2.14.14 from 8:00 a.m. to 11:30 a.m. and then took 4.0 hours of vacation time. (RX 8)

Petitioner did not work on 2.15.14 – it was her regular day off. (RX 8)

Petitioner did not work on 2.16.14 – it was her regular day off. (RX 8)

Petitioner received 7.30 hours of holiday pay on 2.17.14. (RX 8)

Petitioner worked for Respondent on 2.18.14 from 5:05 a.m. to 4:00 p.m. (receiving 2.55 hours of overtime paid in cash. (RX 8)

The Daily Staff Attendance Reports for the State of Illinois Department of Human Services were admitted as RX 9. Petitioner's name was not included in the attendance report for February 17, 2014. (RX 9)

On February 18, 2014 Petitioner completed a Notice of Injury form for Respondent and Tri Star. In it she noted an accident date of February 18, 2014 and a time of 5:02 a.m. She stated that she had reported the accident to her supervisor, Judy Howard-Chappel at approximately 8:00 a.m. At the time of her report, she had not sought any medical treatment. Petitioner reported that she was injured while walking into the building to sign in and she slipped on the ice. There were no witnesses. (RX 1)

An Illinois Form 45 was completed on February 18, 2014 by Jennifer Boisselle from Tri Star. In the form, she noted that Petitioner had slipped on ice but kept herself from falling but her lower back was now hurting and she was experiencing a shooting pain down her right leg. (RX 2)

Petitioner also completed a Workers' Compensation Form on February 18, 2014. She reported that she was assigned to "General Stores" when the injury occurred and that the accident occurred outside the Administration Building while she was walking towards the building. She thought she had pulled muscles to her lower back and she was feeling pain to her right leg. (RX 3)

Petitioner's supervisor completed a Supervisor's Report of Injury or Illness on February 18, 2014. She noted Petitioner was working on temporary assignment as a storekeeper and her job required

her to load, unload and pick product. She confirmed Petitioner's description of the accident and claimed injuries. (RX 4)

Petitioner was seen at St. Mary's Hospital Emergency Room on Tuesday, February 18, 2014, arriving at 4:26 p.m. on a walk-in basis. Petitioner gave a history of slipping on ice that morning and catching herself with subsequent lower back pain shooting into her right leg. She gave an onset of twelve to twenty-four hours earlier and described her pain as "10/10." She was ambulatory at the scene and denied any loss of consciousness. Petitioner had taken some acetaminophen at 2:00 p.m. but it provided no relief. A CT without contrast was unremarkable, but Petitioner was in significant pain. ER notes noted that Petitioner "remain[ed] tearful" while waiting. A pain drawing showed lower right back pain with radiation down into the right lower leg. Petitioner was diagnosed with lumbosacral radiculopathy and a muscle strain, given a morphine injection and narcotic oral medication for pain (which offered some relief), and taken off work until cleared by workman's compensation or her primary care physician. She left reporting her pain was better and she appeared to be more comfortable. (PX 3)

Petitioner presented to the Work Safety Center at St. Mary's Centralia on February 20, 2014 with complaints of persistent low back pain radiating down her bilateral lower extremities. (PX3, 2/20/14). She gave a history of having slipped on ice and fallen. According to the note, "Prior history of back problems; recurrent self-limited episodes of low back pain in the past." She denied any numbness in her legs and primarily complained of pain in her anterior thigh. Petitioner's physical examination was positive for back pain with flexion, extension, rotation, lateral bending, moderate leg pain with back flexion, moderate limitation of motion in flexion, extension, rotation, lateral bending, paraspinal muscle spasm on the right, tender spinous processes at about L5, straight leg raising on the right side at about 30 degrees, some decreased DTR on the right, and positive sciatic notch tenderness on the right. She denied any numbness in her legs. Petitioner was restricted to light/sedentary duty with no lifting over 10 pounds and stipulations that Petitioner would only be capable of 1-33% of activity and be allowed to sit, stand and walk as needed for comfort. If no work was available within those restrictions, Petitioner was to be sent home. (PX 3)

Petitioner returned to the Work Safety Center on February 25, 2014, reporting that she was not much better and that she was experiencing sharp pain in her lumbar spine rated 10 on a scale of 10 and intermediary pain rated 3-4 out of 10 that continued to radiate down her legs. An MRI was ordered and Petitioner was to return thereafter unless she needed to be seen on an emergent basis. Petitioner reported that if she stood for more than about 15 minutes, her legs would begin to feel weak and shaky. Her gait was described as mildly antalgic. (PX3)

Petitioner underwent a lumbar spine MRI at St. Mary's on February 27, 2014. It revealed mild degenerative disc disease at L4-5 with desiccation and mild narrowing and a mild annular disc bulge but no central canal stenosis, neuroforaminal narrowing or nerve root impingement. (PX 3)

On March 3, 2014, Petitioner returned to St. Mary's Work Safety Center where she reported ongoing pain that continued to go to her legs and buttock. She remained on sedentary duty at work and was noted to be moving slowly with limited range of motion of her back. Petitioner was referred for physical therapy. She was to return in about two weeks. (PX3, 3/3/14)

Petitioner signed her Application for Adjustment of Claim herein on March 31, 2014. (AX 2)

Petitioner saw Dr. David Raskas on April 7, 2014. Thereafter, Dr. Raskas sent a letter to Tri Star Risk Management regarding his examination. He noted that he had previously cared for Petitioner for neck problems back in 2008 but that she was now presenting with the chief complaint of back pain, and a secondary complaint of right buttock pain. He wrote:

> She was in her usual state of health, not having any consistent low back pain. I had taken care of her for prior neck problems back in 2008. She slipped on the ice while signing into work. She fell and she caught herself on her outstretched right hand. She had the immediate onset of some discomfort progressively in increased [sic] pain. (PX 4)

Dr. Raskas reviewed the CT and MRI ordered by St. Mary's Good Samaritan, and noted the MRI showed disc dehydration at L4-5 and L5-S1, and disc bulging at L4-5. He also noted loss of normal nuclear pattern at L4-5 and L5-S1, but no significant disc replacement. Petitioner's pain was 6 on a scale of 10 at the time of the visit. Dr. Raskas' physical examination was positive for significantly limited range of motion. He reported that her back pain was worse than her leg pain. He further noted that Petitioner's actual MRI films show disc dehydration at L4-5 and L5-S1 and loss of normal nuclear pattern at L4-5 and L5-S1 in addition to the disc bulging at L4-5. Dr. Raskas diagnosed Petitioner with a lumbar strain further noting that she might have some radicular irritation with the strain associated with aging changes in her spine. He recommended a trial course of non-steroidal anti-inflammatory medication, physical therapy, and bracing for Petitioner's lumbar spine, and opined that the need for treatment was directly related to the slip and fall accident that occurred at work. (PX 4, p. 2)

Petitioner presented to Apex for physical therapy commending on April 8, 2014. She gave an onset date of February 18, 2014 and attributed her injury to falling. She was currently working light duty at Murray Center and noting constant pain made worse with twisting and turning and standing for too long. She continued with therapy through May 2, 2014. At the time of her final visit she reported her back was feeling about the same with her worst pain a "7/10" and her current pain a "3/10." Her pain was noted to be in the right buttock and going down her leg. Petitioner expressed uncertainty as to whether she could return to work full duty but wished to try. (PX 5)

Petitioner reported improvement with physical therapy upon her return to Dr. Raskas on May 12, 2014. (PX4, 5/12/14). Although Petitioner's leg symptoms had lessened, Petitioner continued to

have low back pain rated at a level 2. Dr. Raskas recommended a trial of return to full duty work. A letter was sent to Tri Star regarding the visit.

When Petitioner returned to Dr. Raskas on June 16, 2014, Dr. Raskas noted Petitioner was experiencing "a fair amount of pain in her right buttocks area" which was tender to palpation. Physical examination was positive for tenderness over the sciatic notch and limited range of motion of the lumbar spine. She had returned to regular duties since their last visit. Dr. Raskas assessed Petitioner with possible lumbar disc displacement, and recommended epidural steroid injections given the escalation of Petitioner's symptoms. He also imposed work restrictions. Again, Tri Star was kept informed. (PX 4)

Dr. Hurford performed injections on June 24, 2014, and July 1, 2014. (PX6). Dr. Raskas also placed Petitioner back on restricted duty. (PX4, 6/16/14).

On July 8, 2014, Petitioner returned to see Dr. Raskas. In his report to Tri Star, he noted that Petitioner was continuing to experience pain in her back that was radiating into, not only her right buttock, but also her left leg. Dr. Raskas again recommended that Petitioner return to regular work duties, and if she continued to have a pain level of 5 out of 10, he would have Petitioner complete an Oswestry score scale. On exam, she had mild limitation in range of motion in flexion/extension but strength was normal and straight leg raise testing was negative. (PX 4)

Petitioner returned to see Dr. Raskas on August 18, 2014. In his report to Tri Star he noted that Petitioner was having increased pain in her back radiating into her right buttock. Petitioner reported difficulty sleeping secondary to pain, and her Oswestry score was 36%. Physical examination continued to be positive for mild limited range of motion. He noted she had been working regular duties and experiencing increasing symptoms. While he kept her on regular duty, Dr. Raskas recommended Celebrex and Neurontin to see if the nerve medication would be effective in controlling her symptoms. She was to return in three months unless things worsened significantly. (PX4)

Petitioner returned to Dr. Raskas on November 17, 2014, with persistent complaints of low back pain and right buttock pain with spasms. She was working full duty and had been exercising to try and strengthen her core muscle. Dr. Raskas noted that her back pain appeared "secondary to the degenerative changes on her x-rays." She was not showing symptoms consistent with nerve root compression. The tenderness he noted on exam was felt like that of muscle spasms. He felt she should continue with her home exercise program. He did not feel she was ready for a lumbar fusion which would be the surgery of choice to address her problem. She was allowed to continue working without restrictions and to return or call if the doctor was needed. (PX 4)

Petitioner returned to Dr. Raskas on February 13, 2015, with persistent increasing pain in her right buttock radiating into her leg. Physical examination confirmed a worsening of Petitioner's condition. Straight leg raise was positive on the right with a positive bow string test. Dr. Raskas also noted that Petitioner looked significantly more uncomfortable. Dr. Raskas stated:

> Given the increasing pain that she is having in her right buttock radiating down her right leg, I think the herniation that she has at L4-5 may be progressing. I am recommending repeating her MRI scan. We are going to give her a Medrol Dose Pak and some Tramadol.

Petitioner, however, remained on full duty. (PX 4)

Petitioner presented to St. Mary's on February 17, 2015 reporting she was having low back pain that "started today." Petitioner reported falling at work in 2014 and having had back problems since then for which she was seeing Dr. Raskas. She was scheduled for an MRI on Friday and had a reported history of a disc herniation for which she had been prescribed steroid medication and tramadol, the latter of which caused nausea. Petitioner gave a further history of having shoveled snow the day before that aggravated her back pain. Petitioner's pain was in the center and right of her back and radiated down her right leg. She denied any recent fall or trauma and measured her pain at "10/10." She denied any numbness or tingling. On examination Petitioner displayed decreased range of motion, tenderness and spasm. She was diagnosed with acute low back pain and given medication. (PX 3)

On February 19, 2015, Petitioner underwent a new MRI, which revealed evidence of mild disc degeneration at L4-5 and L5-S1 and mild bilateral facet arthritis. All other areas of the lumbar spine were normal. (PX7)

Petitioner returned on March 3, 2015, to Dr. Raskas. (PX4, 3/3/15). In his letter to Tri Star, Dr. Raskas observed:

> She is miserable with pain radiating down her leg in the right leg. She is tearful during the exam. It has been very hard for her to work. She has internal disc disruption at the L4-5 which I have seen on previous examinations and is most likely the source of her symptoms. *Id.*

Petitioner's physical examination continued to demonstrate positive straight leg and bow string testing. Dr. Raskas reviewed Petitioner's new MRI, and concluded that Petitioner suffered from internal disc disruption at L4-5 and possible right SI joint dysfunction. He recommended two SI joint injections and took Petitioner off work.

The first injection was administered on that day of March 3, 2015, by Dr. Wayne. Dr. Wayne's impression was status post slip and near fall with a resultant right lumbo-pelvic injury with right sacroiliac dysfunction. His examination noted a slow gait and moderately restricted lumbar range of motion. Straight leg raising was positive on the right. The injection reduced Petitioner's pain from 10 to 5-6 out of 10. However, its effects wore off within an hour. (PX4, 3/12/15). Petitioner presented for the second injection, administered on March 12, 2015, with a noted slow and antalgic

gait, and reported 10 to 15% improvement in pain following the injection. Overall, however, Petitioner was worse following the second injection. (PX4, 3/17/15).

Dr. Raskas re-examined Petitioner on March 17, 2015. In his letter to Tri Star Risk Management he noted that the first injection had provided about 50% relief and the second one "just made things worse." He again noted Petitioner was miserable with pain and she looked significantly more uncomfortable. Petitioner was taking narcotics to help with pain relief. Given the disc abnormality at L4-5 Dr. Raskas recommended a discogram at L4-5 and L5-S1. (PX 4)

Petitioner's discogram on April 2, 2015, performed at Excel Imaging, revealed left lateral annular tears at both L4-5 and L5-S1 with reproduction of pain consistent with positive discogram results at both levels. (PX8). The impression of the post discogram CT was left lateral annular tears at L4-5 and L5-S1 probably with a small additional disc herniation at the L5-S1 level with the appearance consistent with the findings on discogram. (PX 8)

Petitioner returned to Dr. Raskas on April 10, 2015, who noted the positive reproduction of Petitioner's pain at L4-5 and L5-S1 with annular disruptions at both levels. Dr. Raskas noted that Petitioner's problem had been ongoing for 14 months with no improvement from extensive conservative care. Petitioner required narcotic medication just to be able to manage her pain and she was unable to work. Dr. Raskas recommended an anterior fusion from L4 to S1 with posterior facet fusions. He also noted that if Petitioner suffered persistent buttock pain, an SI joint fusion might need to be added. (PX 4)

On April 22, 2015 TriStar forwarded a letter to Dr. David Robson regarding Petitioner requesting an independent medical examination. In the letter the claims examiner advised the doctor that Petitioner had been a support service worker for Respondent and had reported a low back injury "as a result of an assault from a resident on 2/18/2014." The doctor was asked to address certain questions set forth therein after reviewing records provided to him. (RX 7, pet. dep. ex. 2)

Petitioner was examined by Dr. David Robson on May 6, 2015. A report followed. It was the understanding of Dr. Robson that Petitioner slipped on ice and "fell backwards on the ice injuring her lower back." He noted her complaints included lower back pain described as aching, stabbing, and burning in nature with radiation down the posterior aspects of her legs bilaterally. Petitioner described pain worse after exercise, with sitting, during exercise, with work, with ice, with standing, with walking, with bending forwards, with twisting/turning, and with cold weather.

Dr. Robson described his physical examination as entirely normal. Dr. Robson stated that the CT discogram showed diffuse bulging L4-5 with no evidence of herniation at L5-S1. He concluded that Petitioner merely suffered a strain on February 18, 2014, for which she had exhausted all conservative care, and that she could return to full duty work. He recommended "continued observation and acceptance of her condition." He agreed that Petitioner's findings on exam supported her subjective complaints, but he felt that Petitioner's radicular pain was connected to pre-existing degenerative disc disease at L4-5 rather than the February 18, 2014 injury. (RX 5)

Petitioner again reported to the emergency room at St. Mary's Hospital on May 25, 2015. She complained of lower back pain going into the left side and down her left leg. She denied any trauma but stated that the pain had started after bending over and then straightening up. Petitioner described worsening pain with movement. She was noted to have chronic back pain with lumbar disc problems. Petitioner was given more injections and prescription pain medication and told to follow up with her primary care physician or return if her symptoms worsened. (PX 3)

Dr. Raskas testified by deposition taken on July 15, 2015. (PX9). Dr. Raskas is an orthopedic surgeon board certified in the State of Missouri. Approximately 20 to 25% of his patients have workers' compensation or personal injury claims. About 3 to 4 times per week he performs independent medical examinations for both Missouri and Illinois claims and on a 50/50 basis for both sides. (PX 9, pp. 1-6)

Dr. Raskas testified that he previously treated Petitioner in 2007 or 2008 for a neck injury that ended up requiring a two-level disc replacement after which she resumed full duty work. Dr. Raskas further testified that Petitioner did not have any lumbar complaints when she came under his care for neck problems in 2008. (PX 9, pp. 6-8)

Dr. Raskas testified that thereafter he did not see Petitioner again until April 7, 2014 at which time she provided him with a history of having fallen when she slipped on ice and catching herself on her right hand that was outstretched. She was primarily complaining of low back pain along with right buttock pain. It was his understanding that Petitioner was not experiencing any "consistent low back pain" when the accident occurred. Dr. Raskas was aware that she subsequently underwent a CAT scan and an MRI scan and he had reviewed those and felt they showed disc dehydration at L4-5 and L5-S1 along with a bulging disc at L4-5. He also saw some loss of normal pattern of the nucleus at L4-5 and L5-S1 but no nerve pinching or anything like that. (PX 9, pp. 8 – 9)

Dr. Raskas testified that a disc bulge is not necessarily a disc herniation. He explained that there could be a tear in the disc or something but two months into an injury one is not really going to concern oneself with a possible tear in the disc because sometimes these are just normal aging findings on an MRI. Her only pertinent finding on physical examination was limited range of motion of her lumbar spine and he felt she had a lumbar strain with some possible radicular irritation because of her right buttock pain. He recommended non-steroidal medication and physical therapy with bracing as there was no obvious neurological deficit. (PX 9, pp. 9 – 10)

Dr. Raskas testified that it was his opinion that Petitioner's condition was caused by the February 18, 2014 accidental injury, given that Petitioner did not have any back problems when he treated her in the past. (PX 9, p. 11) He gave her some work restrictions and told her to follow up which she did on May 12, 2014. (PX 9, p. 11)

Dr. Raskas testified that when he re-examined Petitioner on May 12th she was having a good day and described her pain as a "2/10." She felt like her leg symptoms had resolved and he felt her

lumbar strain was resolving. Dr. Raskas further testified that he wanted her to go back to work and really try to do the things she was normally capable of and he would re-examine her in four to six weeks. Dr. Raskas then re-examined her and she had started having increasing pain in her back and right buttock area. He noted tenderness on palpation and he felt she was having an "escalation of symptoms." (PX 9, pp. 11 – 12) Since he had already recommended conservative treatment, Dr. Raskas recommended epidural steroid injections as it had been four months post-accident and he didn't feel he was dealing with a strain since most strains resolve in three to four months. (PX 9, p. 12)

Dr. Raskas was asked if Petitioner reported any intervening accidents or traumas to him after the February 18, 2014 accident and he responded that he didn't remember. He testified that up until June 16 he didn't note anything but he recalled she would tell him how sore she was after working and things of that nature. Therefore, he again put her on restrictions and she underwent the injections which didn't provide a lot of sustained relief. When asked if her failure to experience sustained relief meant anything, he responded that it didn't really tell him anything except that another conservative treatment measure had failed. (PX 9, pp. 12 -13)

Dr. Raskas testified that he had Petitioner return to full work duties in July and she returned in August. At that time he noted her Oswestry score was 36 percent explaining that the Oswestry test is a patient questionnaire that gives the doctor a quantification of how pain is affecting the patient's life and, in her case, it was moderate. He recommended Celebrex and Neurontin. (PX 9, pp. 13 – 14)

Dr. Raskas further testified that he re-examined Petitioner in November of 2014 and she was complaining of both low back pain and right buttock pain. Petitioner was reportedly trying to exercise on her own but was tender to touch over the right posterior portion of her pelvis. Dr. Raskas testified that he still wanted to pursue conservative treatment as the recommended surgical procedure would be a fusion and he didn't want her to undergo that if she didn't have to. Therefore, he recommended a wait and see approach and that she try and work full duty. (PX 9, p. 14)

Dr. Raskas testified that Petitioner returned to see him in February of 2015 reporting increasing pain in her right buttock going down her right leg. On examination Petitioner had a positive straight leg raise on the right with a positive bowstring test which appeared like sciatica to him. Dr. Raskas testified that at that point he thought her disc injury was perhaps progressing and, therefore, he felt another MRI was worthwhile. His diagnosis at that point was sciatica. (PX 9, pp. 14-15)

Dr. Raskas further testified that Petitioner continued to work full duty and when she returned to see him in March of 2015 she still had pain down her leg and into her right leg and was tearful during her examination. He noted that she was trying to work full duty but reporting it was very hard. Dr. Raskas explained that, at that point, he was very suspicious of some internal disc disruption at L4-5 as some of her sacroiliac joint maneuvers were provocatively positive. Therefore, he recommended

some SI joint injections. Dr. Raskas testified that the updated MRI was very similar to the first one and he noted internal disc disruption at L4-5. (PX 9, pp. 15-16)

Dr. Raskas testified that throughout his entire time treating Petitioner, she exhibited no signs of symptom magnification or malingering. (PX 9, p. 16) Dr. Raskas testified that he took Petitioner off work again as of March 3, 2015. She underwent the injections and when he next saw her she was miserable complaining of both right buttock pain and central low back pain. Dr. Raskas testified that, at that point, after Petitioner had failed over a year conservative treatment, he recommended a discogram. With regard to the procedure itself, he stated:

> It's specifically to look for symptomatic annular tears and that would be the purpose of it because you can have a relatively mild-looking MRI but have a significantly clinically disabling condition of an annular tear with discogenic pain, which she had in her neck years ago and had surgery for and did well. (PX 9, pp. 17-18)

Petitioner's discogram revealed annular tears which reproduced her pain at L4-5 and L5-S1. Dr. Raskas explained that an annular tear is a tear in the outer portion of a disc and can cause chronic pain syndrome. He testified that annular tears can produce low back and leg pain, and that not all leg pain is related to nerve root compression. (PX 9, p. 18)

Dr. Raskas testified that after reviewing the discogram he recommended an anterior/posterior fusion at L5-S1. He did not want to do anything with her SI joint but that it might be a problem and have to be addressed with future surgery. He did want to address the SI joint because Petitioner didn't really have two positive blocks as required by diagnostic criteria. He further testified that he based his recommendation on Petitioner's young age, "examining her, following her over time, watching her condition deteriorate, get worse." He noted that her physical examination and MRI showed disc dehydration and abnormality. (PX 9, p. 19)

Dr. Raskas testified that he has taken Petitioner off work until after her surgery and feels that Petitioner will likely not improve without surgery, and that Petitioner will end up permanently disabled given her level of pain and her requiring narcotic medication. He also testified that Petitioner's narcotic medication will work less and less because she will develop a tolerance to it, and then Petitioner would not only have a back problem, but also a narcotic dependency problem. (PX 9, p. 19)

Dr. Raskas further testified that Petitioner's condition has never returned to baseline, but has always worsened with work activity since her accident. He explained that she got a little bit better right at the beginning but as soon as she increased her activity level by resuming regular work duties things would worsen. (PX 9, p. 20) Dr. Raskas also testified that Petitioner is not at maximum medical improvement and that the recommended surgery and Petitioner's time of work is causally related to the February 18, 2014 accidental injury. (PX 9, pp. 20, 22)

Dr. Raskas also testified that he reviewed Dr. Robson's IME report of May 6, 2015 and he disagreed with the doctor's assessment that Petitioner's injury should be characterized as a lumbar strain. He explained that a lumbar strain/sprain usually improves within a few months and he's dealing with a patient fifteen months post-accident still having symptoms. Dr. Raskas believed that Dr. Robson may have been his co-surgeon on Petitioner's cervical spine surgery in 2008. (PX 9, p. 21)

On cross-examination Dr. Raskas explained that his surgery would address Petitioner's disc injuries at L4-5 and L5-S1. He explained that the annular tears cannot be repaired; rather one must remove the disc in its entirety and either replace it with an artificial disc (which for two levels is not FDA approved) or fuse them. It is hope that the surgery will alleviate her back, right buttocks, and right leg pain. He acknowledged that nothing on the imaging studies indicated any nerve compression which would cause her leg pain; however, he felt it was very common for patients with annular tears to have referred pain in their leg. Therefore, if one removes the annular tear one can remove the leg pain as not all leg pain is related to nerve root compression. Dr. Raskas estimated that the chances of Petitioner never returning to work for Respondent full duty were less than 50 percent. He didn't think she would have an immediate difficult time with recovery, but she has a risk for adjacent segment problems which could be accelerated by smoking but it probably won't develop for several years. (PX 9, pp. 22 -26) He also felt there might be a 20 to 30 percent change Petitioner could end up with permanent restrictions but he couldn't give a formal medical opinion on that. (PX 9, p. 29)

Dr. Raskas also testified that whether Petitioner slipped and caught herself with her hands or fell and hit the ground directly would make no difference in his opinion as to causation. (PX 9, pp. 29-30) The following exchange then occurred:

"Q. I guess what I'm confused that, I mean, she's a fairly young woman at the time of her accident. She's 37, seems to be in good health. I guess just kind of a simple slip and catching herself doesn't seem to be very traumatic in my head, I guess.

A. Well, I guess you don't – the thing is, though, it seems like that but, like, you know, have you ever, like, been walking down the stairs in the middle of the night and you're not looking at the stairs? And you think you're done with the stairs and you're not. And you kind of miss the next step. And you can really kind of jolt yourself just taking – just going down one step, you know, because you're not prepared for that next step because your mind, your reflexes, your balance, things of that nature, don't see it. You don't see it coming. …It's the same thing with some,.., car accidents that sometimes are relatively minor impacts [and] can produce annular tears and disc injuries,…, -- you're not prepared for the load."

Q. Now, is that something you would normally see for somebody at 37 and in good health, to have kind of a grossly minor jolt to experience a disc bulge or annular tear as a result?

A. I think it's fairly common. I mean, she already had an annular tear in her cervical spine with an injury. I can't tell you – I don't remember the details of that injury so maybe there's some predisposition that she has for that could be a contributing factor.

Q. And if the previous injury was as a result of a kind of altercation or more serious trauma, would that change your opinion?

A. No, not really. (PX 9, pp. 30 -31)

Dr. Raskas further testified that he had no records stating that Petitioner had any prior treatment to her lumbar spine nor did he have any independent recollection of it. As far as he knew, based on what she told him, she had not had any problems of any "significance" with her lumbar spine. The following exchange then occurred:

Q. So if, in fact, at some point in time right after you treated her for her cervical condition, if she had received treatment for a lumbar condition where she complained of low back pain with pain radiating into her leg, would that be something that would be relevant to your causation opinion today?

A. Well, I think it would be, you know, if it is something that occurred and it went away after a month or two or three of treatment and then you don't have any problem for, you know, another five years, then I don't think it would be relevant.

Q. Okay.

A. If it was a situation where she was seeing her, you know, family physician regularly for low back pain problems, seeing a chiropractor regularly for low back pain problems over that five year period of time, that may change my opinion. ….

Q. So sometime from 2008 to 2010, we'll just assume [hypothetically] at some point in time that she had some treatment to her low back with pain radiating into [her] legs. Could that have been evidence of annular tears at the same place that she has them now?

A. Sure, it could be, it's possible. (PX 9, pp. 31-33)

Dr. Raskas acknowledged that the February 18, 2014 CT scan showed nothing significant. He added that the February 2014 MRI not only showed a positive finding at L4-5 but also abnormal nuclear patterns at L4-5 and L5-S1. He agreed that disc dehydration is aging and that disc bulges can be due to degeneration or idiopathic in nature. He testified that he reviewed the films. He agreed that he was unable to identify anything acute on the films. (PX 9, pp. 33 -3 4)

Dr. Raskas was asked about his office entry of November 17, 2014 in which he wrote that he suspected Petitioner's low back pain was secondary to the degenerative changes on her x-ray as she wasn't having any symptoms consistent with nerve root compression. Specifically, he was asked if he meant, at that time, that he believed her low back pain was due to the degenerative changes seen on x-ray and not the slip at work and he replied, "No." (PX 9, p. 35) He went on to

explain that she had degenerative age-related findings on her MRI but she had also experienced a trauma and annular tears are a type of traumatic disc injury and can be seen on MRI as aging degenerative conditions. Thus, it takes the discogram to definitively determine it's an annular tear. (PX 9, pp. 34-35)

Dr. Raskas also testified that the MRIs did not show any nerve root impingement. Rather than pursue other diagnostic considerations to determine/explain her radiating leg pain, which would be extensive, he felt it wiser to pursue conservative treatment at that time. When asked if it was more probable than not that a patient would experience some relief with an epidural injection if the pain was coming from the level where the injection was given, he replied "No." (PX 9, pp. 35-36) He added the risks of an injection are minimal and the goal is to try and provide some relief. (PX 9, p. 37)

Dr. Raskas agreed that someone could call the MRI findings from February of 2015 degenerative in nature. He also agreed there was no evidence of nerve compression in that MRI. He agreed that the discogram was performed fourteen months after the accident and that annular tears can be degenerative in nature and that the discogram did not elicit her leg symptoms only low back pain. (PX 9, pp. 38-39)

Dr. Raskas, on further cross-examination, was asked to explain the difference between radiating leg pain and radiculopathy. He testified that in order to really have radiculopathy one must have neurological findings following a radicular pattern. If it's not radiculopathy it is referred or radiating leg pain. Symptoms of SI joint dysfunction include pain over the SI joint in the posterior portion of the pelvis (to the side of the gluteal fold) and occasionally referring to the groin or down the buttock. Dr. Raskas has even seen it radiate to the knee. However, it's typically a lateralizing pain without a predominance of central low back pain. Dr. Raskas testified that it can be diagnosed with provocative maneuvers and injections but not MRIs or x-rays. The dysfunction can cause inflammation in the SI joint which might evidence itself on CT or an MRI as sclerotic arthritic changes, possibly. He noted, however, that Petitioner had provocative pain maneuvers , the gold standard, for SI joint dysfunction. (PX 9, pp. 39 – 42) In his experience, the buttock radiating pain may go away with the surgery he has recommended. (PX 9, p. 43) The diagnosis of SI joint dysfunction remains "on the table." (PX 9, p. 45) He further testified that her provocative maneuvers were positive on the right and negative on the left. He acknowledged that SI joint dysfunction can be idiopathic; however, in Petitioner's case, it is traumatic. (PX 9, p. 46)

Dr. Raskas was asked about Petitioner's early treatment visits with him and her progression of symptoms and improvement and whether or not that would indicate, like Dr. Robson suggested, that Petitioner had a lumbar strain that had resolved and that her primary complaint then became SI joint dysfunction to which the doctor replied "No" and explained that she still had back pain that did not resolve. He did not believe that SI joint dysfunction caused central low back pain. Rather, it

has to lateralize. He noted that by July 8, 2014 Petitioner still had a major complaint of low back pain radiating into her right buttock and going down her left leg which would not be explained by a lumbar strain. (PX 9, pp. 46 – 49) Dr. Raskas further testified that an annular tear could cause left leg radiating pain. He also agreed that SI joint dysfunction could cause lumbar pain but it would have to result in a predominance of unilateral symptoms. He also explained that he had Petitioner undergo the Oswestry test because he wanted an idea of how much everything was really bothering her since it had been ongoing for several months. The score showed she had a moderate disability and the doctor did not feel that indicated that her pain complaints were disproportionate to her disability. (PX 9, pp. 49 – 51) Dr. Raskas again reiterated that Petitioner has SI joint dysfunction and annular tears which all have the same etiology (ie., the accident in February of 2014). When asked if his opinion was based upon the assumption that Petitioner did not have the same or similar complaints prior to that time, he responded (No, not entirely." He believed, based upon her history, that she had no active ongoing back and/or right leg pain complaints that were under substantial continuous treatment prior to this injury, that she was able to work full duty without such complaints and that that the symptoms in her back and leg she reported to him were brought on by her injury. (PX 9, p. 52)

On redirect examination, Dr. Raskas was asked to assume Petitioner had some sort of symptomatology similar to what she experienced after February 18, 2014 and whether that would change his opinion that the accident caused an aggravation. He replied that if there was some record in the past where she had some back pain and some radiating leg pain and it went away, that would give rise to two possibilities. One is that she inured her back and could have developed an annular tear. It then would have been in a weakened state such that when she had her 2014 injury it produced the symptoms that now have not gotten better. Thus, she would have had an aggravation of a pre-existing condition. He also testified that Petitioner's need for treatment was causally related to the February 18, 2014 accidental injury. (PX 9, pp. 52- 55)

On about July 27, 2015 Respondent's attorney requested authorization to have Dr. Robson review Dr. Raskas' deposition and possibly issue an addendum. (RX 7 – pet. dep. ex. 3)

Dr. Robson issued a note on August 10, 2015 after having reviewed Dr. Raskas' deposition. He felt nothing in the deposition changed his mind about his earlier opinions. He still felt Petitioner had no evidence of nerve root impingement and only minimal structural changes at L4-5 and L5-S1. Noting her only positive finding was a discrogram, he added that such a procedure is "fraught with subjective bias." (RX 6)

Dr. Robson was deposed on August 27, 2015. (RX 7) Dr. Robson is a board certified orthopedic surgeon engaged in private practice in St. Louis County. He performs approximately five independent medical examinations per week and sees about sixty patients per week. The cost of an

independent medical exam can range from $800.00 up. He treats lumbar conditions and does so both conservatively and surgically. (RX 7, pp. 1 – 8)

Dr. Robson testified that he examined Petitioner on May 6, 2015. As part of his exam he reviewed records from Dr. Raskas, Dr. Wayne, St. Mary's Hospital, and imaging studies from 2014 and 2015 along with the CT discogram. Dr. Robson testified that he reviewed the actual films and performed a clinical examination on Petitioner after first taking a history. (RX 7, pp. 8-9)

Dr. Robson testified that Petitioner's physical examination was entirely normal. He observed her moving in and around the office, performed a neurological exam of her lower extremities, performed range of motion tests on her lumbar spine and hips, did a straight leg raise test, and palpated her lumbar spine and sacroiliac joints for tenderness. He testified that she claimed to have severe pain with pain in her low back and the posterior aspects of both of her legs. By history, she had slipped and fallen backwards on ice, injuring her low back. (RX 7, pp. 9 -11)

Dr. Robson was of the opinion Petitioner had degenerative disc disease at L4-5 that was strained by her fall. He agreed with all of the conservative treatment Petitioner had, which included physical therapy, medications and injections, but recommended against any further treatment, including surgery. He did not feel she needed to undergo a fusion given she lacked any significant objective findings to rationalize a surgery of that magnitude. Her exam was normal, she had very mild changes on multiple imaging studies, and no evidence of instability. He noted that the only positive findings she had was the discogram which he felt was a procedure long debated and of concern due to the subjective bias of the test. He felt her lumbar strain would have resolved within a couple of months of her accident. He felt that, when he saw her, she could work full duty. (RX 7, pp. 11 -12)

Dr. Robson testified that the imaging studies failed to show signs of nerve impingement. He explained that the discogram is a painful test with the patient often times sedated and, after fluid is injected, if the patient says it hurts, a spinal fusion is considered the solution. However, he feels it is a "large leap of faith" to recommended surgery based upon that procedure when all other imaging studies and findings are minimal at best. When asked to explain why the discogram would reproduce Petitioner's low back pain but not her radiating leg pain, he replied, "I think it hurts to have a bunch of junk injected in your disc." (RX 7, pp. 12 -13)

Dr. Robson further testified that she had no objective explanation for her continued complaints of low back pain, especially when she rated them at 90/100. (RX 7, p. 14)

Dr. Robson was asked about his report in which he stated "The patient's objective findings on exam seemed to support her subjective complaints." and explained that that was not accurate but due to a transcription error. He testified that he felt there was a disconnect between her objective findings of normal and her subjective pain complaints of "9/10." (RX 7, p. 14)

Dr. Robson agreed that a patient can have radiating leg pain without nerve impingement being present on imaging studies. He felt it could be due to a contusion or a temporary condition. He agreed that it did not matter if Petitioner actually fell to the ground or not. He believed that something occurred and had no reason to doubt that. (RX 7, pp. 14 – 16)

Dr. Robson was also asked if he found her pain complaints of "9/10" or "90/100" credible and he explained "You know, I have five kids, and one of them can have a cut and scream bloody murder, and the other one can be dripping blood and never complain. So, there's a wide variation of reported pain scores. But generally a score of 9 out of 10 to me would be something severe or life threatening or an open fracture or surgical problem. So, I would say that that's out of line with what I observed on her behavior." (RX 7, p. 16)

Dr. Robson further testified that he saw no evidence of SI joint dysfunction and saw no need for her to undergo an SI joint fusion. He felt, in his experience, SI joint fusions, are extremely rare. He has seen a correlation between it being recommended and the patient have a workers' compensation case. (RX 7, pp. 17-18)

On cross-examination Dr. Robson testified that he performs IMEs for both side about half and half. He acknowledged that he was not provided with any medical records that indicated Petitioner ever had any low back symptoms or treatment before her February 18, 2014 accident. He also acknowledged reviewing Dr. Raskas' deposition before authoring his addendum. He acknowledged he may have assisted Dr. Raskas with the cervical surgery in 2008 and that he has respect for him as a physician and surgeon. (RX 7, p. 27)

Dr. Robson testified that he had no reason to disbelieve Petitioner about her injury as he believed she had an event and she hurt her low back. He acknowledged that she had some difficulty returning to full duty since the accident. He also agreed with Dr. Raskas that Petitioner lacked significant evidence of degeneration in her lumbar spine and that she is relatively young being "30 something." He also agreed that the discography results were positive for pain at L4 to L5 and L5 to S1 which are the two levels Dr. Raskas is recommending for fusion. He also agreed that Petitioner has, essentially, failed conservative treatment. (RX 7, pp. 27 – 30)

Dr. Robson testified that he does not order discograms for neck or back pain. He had been trained to do them and did perform them early on but he no longer feels there is any need for such an invasive procedure and the test is subjective. He acknowledged that other orthopedic spine specialists use them. If the cervical spine surgery Petitioner underwent in 2008 and which he assisted on was done due to discography he would have no reason to dispute it. He agreed Petitioner would be in the best position to tell how her symptoms were progressing and affecting her life. He also acknowledged seeing no reference in other records to any suggestion by anyone that Petitioner was exaggerating or malingering her symptoms. He also agreed that someone's symptoms can be permanently aggravated without seeing an actual change in their pathology on an MRI but he sees it more in the litigated world than in his private practice. (RX 7, pp. 30 – 33)

Dr. Robson agreed that Petitioner has annular tears at the two levels that the discogram revealed. He also agreed that annular tears can produce lumbar spine pain and, possibly, referred pain to the leg. When asked if he agreed with Dr. Raskas' testimony that not all referred leg pain would be related to nerve root compression he initially replied in the negative but then added that "in some sense" he would agree as when one gets a contusion of a nerve. He did not believe annular tears would produce leg pain. (RX 7, pp. 33 – 34)

Dr. Robson also acknowledged that the medical records he reviewed did not show any reference to any other injury to Petitioner's lumbar spine other than the February 18, 2014 injury. He also agreed that the purpose of a discogram is to demonstrate an annular tear but "it's silly" because the "gold standard for seeing an annular tear is an MRI and that was done." As Dr. Robson explained when the discogram is performed one is tearing the annulus to inject dye and it's possible the dye is flowing out of the holes that have been made. He feels the test is fraught with interpretative error and, therefore, the MRI is the reliable test. (RX 7, pp. 34-35) When asked if one cannot always see an annular tear on an MRI, the doctor replied, "I don't know if that's true or not." He was then asked if he saw Petitioner's annular tears on her MRI and he replied, "I can't remember now. I'm like ranting and talking....Looking at the reports there's no reference to an annular tear." However, he did not look at the films for that answer. He acknowledged that he believes she has two annular tears but can't see them on the MRIs; however, he believes the act of performing a discogram tears the annulus to some extent. He added that there needs to be a control level in the discogram – a normal level; however, in Petitioner's case they only injected L4-5 and L5-S1. That makes the test very subjective. (RX 7, pp. 34 – 38)

On redirect examination Dr. Robson explained that when one sees dye leaking on a discogram one cannot determine if the dye is leaking from an old annular tear or a new tear caused by the discogram. (RX 7, p. 39)

Petitioner's case proceeded to arbitration on September 9, 2015. The issues in dispute were: accident; causal connection; medical bills; temporary total disability; prospective medical care; and credit for overpayment of temporary total disability benefits. Trisha Shipley was present as Respondent's representative. Two witnesses testified at the hearing: Petitioner and Trisha Shipley.

Petitioner called Trisha Shipley during her case-in-chief. Ms. Shipley testified that she is the work comp coordinator for Respondent and, as such, was familiar with Petitioner's claim. She acknowledged that Petitioner filled out an Employee's Notice of Injury indicating that she had slipped on ice when she went to sign in and that the accident occurred at approximately 5:02 a.m. Ms. Shipley was asked if she knew what Petitioner did the night before her accident and she replied that she didn't know. When asked if it was her understanding that Petitioner had stayed overtime the night before with a co-worker shoveling snow, she replied that she didn't know. She was then asked if Petitioner so testified would she have any reason to disbelieve her and she replied she would not.

Ms. Shipley then testified that there are several entrances to the building but the one Petitioner was going into was the main entrance where Petitioner would sign in. She acknowledged that most of the other entrances were locked at 5:00 a.m. She also testified that there is one entrance in the back of the building that is always open. Ms. Shipley further testified that Petitioner was working in the storeroom when her accident occurred and the back entrance would have been out of her way.

Ms. Shipley also testified that she performed no inspection after the incident occurred. When asked if she had any information whatsoever to doubt that the accident happened the way Petitioner reported it, Ms. Shipley testified "No."

Ms. Shipley testified that she didn't believe that Petitioner had any prior back workers' compensation claims although she believed she might have had some claims. She further testified that she wouldn't know if Petitioner had ever been disciplined in any way while working for Respondent and she replied that she wouldn't know without looking at her personnel file.

On cross-examination Ms. Shipley agreed that where employees sign in is depends upon their job assignment. She also acknowledged that where Petitioner would sign in is also where the general public would sign in.

Ms. Shipley also testified that Petitioner had been previously terminated from her employment with Respondent but she did not know why without looking in the personnel file.

Petitioner testified that she is a Support Service Worker for Respondent. Petitioner testified that the night prior to her accident, she left the storeroom at 4:00 p.m. and worked from 4:00 p.m. until midnight removing snow. Petitioner identified Jim Opolony and Tom Dodson as the people she worked with that night. Petitioner testified that she was engaged in snow shoveling, putting down salt, and trying to keep everything clear for the employees to go in and out of the buildings safely. Petitioner testified that she was paid for her eight hours of snow removal. Petitioner was then asked what sort of physical activity she was required to do while shoveling snow. Respondent's attorney objected to that question on the basis of relevance indicating that Petitioner had not filed any complaint or alleged that her injury occurred because of snow removal. In response, Petitioner's attorney represented that Dr. Robson, Respondent's examining physician, had indicated that Petitioner's physical problems were degenerative in nature and not the result of the accident and he wished to show that Petitioner was working eight hours shoveling snow the day before the accident and had never had a back claim in her life until she fell on the ice at work. Petitioner denied having any trouble shoveling snow for eight hours.

Petitioner testified that she then returned to work 5 hours later at approximately 5:02 a.m. to catch up on her paperwork because staff had been reduced from six people to two and they were working overtime to keep up with all the paperwork and job duties. Petitioner testified that it was still dark and the lighting was very dim when the accident occurred.

Petitioner testified that there were only two entrances open at the time when the accident occurred, the front and back entrance. She testified that she was parked directly next to the front entrance of the administration building, which was closest to her assignment. Petitioner testified that she has not ever had any low back injuries or prior workers' compensation claims for her low back. Petitioner testified that she parked her truck, got out and was walking in when her foot slipped out from underneath her and she went back and put her right hand down to catch herself and felt back pain immediately. Petitioner testified that she sought medical care and treatment thereafter as shown in the records.

Petitioner testified that she currently experiences pain in her lower back which radiates to the right side of her buttocks and down her right leg. Petitioner testified that she has also developed problems with her left side of her back and lower extremities, but that her right side is the worst. She described her pain as a stabbing, burning pain which at times becomes severe. Petitioner testified that she has not sustained any intervening accidents Petitioner testified that she wishes to undergo the surgery recommended by Dr. Raskas.

The Arbitrator notes that Petitioner was visibly in pain during the hearing. At the beginning of the hearing while seated next to her attorney, she leaned to the left in order to avoid sitting on her right buttock. She initially sat more straightly during her testimony in a very erect position, but ultimately needed to stand.

Petitioner is currently taking Percocet and Flexeril for her pain. Petitioner testified that she currently experiences pain in her lower back which radiates to the right side of her buttocks and down her right leg.

Petitioner acknowledged that at the time of her hearing she was wearing a bandage on her neck but it had nothing to do with her claim. She also testified that she had been previously terminated by Respondent but it was not job-related; rather it dealt with a DCFS case she had fought. Petitioner also acknowledged a prior workers' compensation claim for her neck which involved disc replacement surgery at two levels. She also had a broken finger.

Petitioner acknowledged receiving temporary total disability benefits for about a month. She also testified that, ultimately, her workers' compensation claim was denied on the basis of accident.

On cross-examination Petitioner acknowledged that she signs in where the public signs in and that she received non-occupational disability benefits while being off work. When asked if she told Dr. Raskas that she fell to the ground, she replied "No" and explained that her left foot never left the ground, only her right foot. She also agreed that her back and buttocks never landed on the ground. Petitioner also acknowledged that her pain currently gets so bad that she will fall but she hasn't seen Dr. Raskas since those symptoms began. However, she has called him and reported the symptoms. She believed she had spoken to his assistant the week before the hearing. She is not scheduled to see him again until surgery is authorized. She has not been to her primary care physician regarding her back.

On September 15, 2015, following the arbitration hearing, Respondent filed a Motion to Reopen Proofs to Supplement the Record. Respondent alleged that new information had come to light following Petitioner's arbitration hearing showing that Petitioner had testified less than credibly. Respondent alleged they had no way of knowing this information at the time of hearing. The parties appeared before the Arbitrator on October 28, 2015, in Collinsville to argue this motion at which time the Arbitrator denied Respondent's Motion to Reopen Proofs to Supplement the Record, and also denied Respondent's request to make an offer of proof on the record regarding Respondent's evidence.

On November 16, 2015, the Arbitrator issued her Decision in Petitioner's favor.

On December 9, 2015, Respondent filed a Petition for Review on the issues of accident, causation, temporary total disability, medical expenses both current and prospective, and the Arbitrator's denial of Respondent's Motion to Reopen Proofs and the limitations of its presentation of an offer of proof.

On June 16, 2016, the Illinois Workers' Compensation Commission, hereinafter the Commission, issued their Decision and Opinion on Review. The Commission found that the Arbitrator erred in not allowing Respondent to go into greater detail in its offer of proof. Therefore, the Commission vacated the decision of the Arbitrator and the award therein, and remanded the matter to the Arbitrator to allow Respondent to present a more formal offer of proof specifically outlining the evidence Respondent wanted to introduce, after which the Arbitrator could decide whether or not to reconsider her denial of Respondent's Motion to Reopen Proofs.

On August 22, 2016, the parties appeared before the Arbitrator in Springfield, at which point Respondent commenced with its offer of Proof. [1]

Respondent first called Ms. Thelma Wooters to testify in its offer of proof. Ms. Wooters testified that she is currently employed at Murray Center. Ms. Wooters testified that in February, 2014 she worked at Murray Center as an Account Tech 1 but she was temporarily assigned as the business administrator at that time. Ms. Wooters testified that she was Petitioner's supervisor at that time as well. Ms. Wooters was shown Respondent's Exhibit 8, and she testified that the exhibit contained the daily attendance reports that she completed in 2014 for the employees under her supervision. Ms. Wooters testified that the document showed when the employees signed in or out, how many hours they worked, or if there was a holiday. Ms. Wooters testified that Respondent's Exhibit 8 was specific to the employees that she supervised.

Ms. Wooters further testified that Petitioner was a support service worker on February 18, 2014, and that she was temporarily assigned as a Storekeeper I. Ms. Wooters testified that attendance

[1] This case is a Zone 1 case and was heard by Arb. Lindsay while she was assigned to Zone 1. Per the Chairman's Office and the agreement of the parties, the case was remanded to Arb. Lindsay (currently in Zone 2) but remains a Zone 1 case.

sheets are kept in different locations at the facility, and if an employee was working overtime in a different department they would actually sign in at that department. However, Respondent's Exhibit 8 was Petitioner's sign in/attendance sheets for her regular job. Ms. Wooters testified that the sign-in sheets in Respondent's Exhibit 8 were located at the switchboard in the administrative building at Murray Center.

Ms. Wooters testified that on February 17, 2014, Petitioner did not work as a support service worker. Ms. Wooters testified that February 17, 2014, was a holiday. Ms. Wooters testified that if Petitioner had worked an overtime shift in a different department it would have been noted on Respondent's Exhibit 8 as well. Ms. Wooters testified that according to Respondent's Exhibit 8, Petitioner did not work at all on February 17, 2014. When asked if it was possible that Petitioner didn't work her normal shift but could have worked overtime somewhere else, she replied that she could have. She explained that it would be possible but it should have been recorded on the timesheets found in RX 8 as well as anytime an employee works overtime or anything like that it has to be notated on a sheet as well. Reviewing RX 8, Ms. Wooters did not see Petitioner was working anywhere whatsoever.

Ms. Wooters testified that she also supervised Tom Dodson. Ms. Wooters testified that Respondent's Exhibit 8 shows that Tom Dodson did not work on February 17, 2014, either. Ms. Wooters also testified that James Opolony was one of her employees she oversaw but he was in the engineering department and it had different sign-in sheets so she would have to look at different documents to determine if he was working.

Respondent then called Danny Reynolds to testify. Mr. Reynolds testified that he works at the Murray Center, which is where he worked in February, 2014 as well. Mr. Reynolds testified that in February, 2014, he was temporarily assigned as an office associate in the engineering department. Mr. Reynolds testified that in that position he took care of daily staff attendance reports for everyone that worked in the mechanical building and boiler house, and he maintained the maintenance log. Mr. Reynolds testified that Respondent's Exhibit 9 is the daily staff attendance report for February 17, 2014. Mr. Reynolds testified that the second page of that document was the attendance sheet where employees would sign in and out for when they arrived and when they left. Mr. Reynolds testified that Petitioner did not appear to have worked overtime on February 17, 2014.

Mr. Reynolds testified that if an employee is working overtime performing snow removal that fell under the purview of the engineering department and the institutional maintenance workers "downstairs." Mr. Reynolds testified that if someone was working overtime for the engineering department doing snow removal, but they weren't normally assigned to the engineering department, they should still sign the attendance sheets.

Mr. Reynolds testified that Respondent's Exhibit 9 did not show Tom Dodson or James Opolony as working on February 17, 2014, either. Mr. Reynolds testified that February 17, 2014, was a holiday so James Opolony would have been off work.

Mr. Reynolds testified that Respondent's Exhibit 10 was the boiler house report. Mr. Reynolds testified that it is for the engineer on duty to write down what happened maintenance- wise throughout the shift, and then it is sent up to the mechanical building where it is kept as a record. Mr. Reynolds testified that the document would show if an employee who was not normally assigned to the engineering department was called in to work in the engineering department. Mr. Reynolds testified that, per Respondent's Exhibit 10, no snow removal was done on February 17, 2014. Mr. Reynolds testified that, per the maintenance log, Petitioner did not do any work on that day. Mr. Reynolds testified that Tom Dodson and James Opolony did not work that day either.

Mr. Reynolds testified that Respondent's Exhibit 9 and 10 were documents that he maintained in the normal course of business.

Respondent next called Tricia Shipley to testify. Ms. Shipley testified that she works at the Murray Center as a Human Resource Specialist, but before that she worked as the work comp coordinator for the Murray Center from 2002-2015. Ms. Shipley testified that she was present for Petitioner's arbitration hearing on September 9, 2015, and heard Petitioner's testimony at that time.

Ms. Shipley testified that Petitioner had never mentioned to her that she had worked overtime on February 17, 2014, nor did she ever mention performing snow removal. Ms. Shipley testified that it was never mentioned in any of Petitioner's work comp paperwork either. Ms. Shipley testified that after the hearing she looked into Petitioner's testimony regarding snow removal out of curiosity. Ms. Shipley testified that she looked into Petitioner's payroll records and at the attendance sheets in various departments and discovered that Petitioner did not work on February 17, 2014. Ms. Shipley testified that Petitioner was normally assigned to the business office, which is what timesheet Petitioner would have been on. Ms. Shipley testified that, prior to Petitioner's testimony about performing snow removal, she would have had no reason to go look at the engineering departments attendance records for Petitioner's attendance records.

After the completion of Respondent's offer of proof, the Arbitrator reconsidered her previous denial of Respondent's Motion to Reopen Proofs. At which time the Arbitrator granted Respondent's Motion to Reopen Proofs. Petitioner was then allowed to cross-examine Respondent's witnesses.

Ms. Wooters was then recalled for cross-examination. Ms. Wooters testified that she was an employee of Respondent in 2015. Ms. Wooters testified that she did not remember the exact date of Petitioner's accident, that she just remembered that Petitioner said that she had fallen and

hurt herself. Ms. Wooters testified that Petitioner had been temporarily assigned as a Storekeeper I, and sometimes storekeepers were called to shovel snow.

Ms. Wooters testified that according to her records the Petitioner was not at the facility on February 17, 2014. Ms. Wooters testified that her timesheets were not wrong, because the payroll supervisor at that time did her job very well and if you did not do something right she would let you know.

Ms. Wooters was also asked if she had ever seen the document marked as "PX A" and she was unsure.

On further redirect, Ms. Wooters testified that Petitioner would still sign in at the main building even if temporarily assigned as a Storekeeper I. Snow removal was not regular duty but Petitioner could be called in by the engineering department if needed.

Mr. Reynolds was then recalled for cross-examination. Mr. Reynolds was asked to identify Petitioner's Exhibit A. Mr. Reynolds testified that Petitioner's Exhibit A was a note he wrote at Petitioner's request. Mr. Reynolds testified that he got Petitioner's accident date from her. Mr. Reynolds testified that he did not put down a date that Petitioner did snow removal in Petitioner's Exhibit A because he did not recall when she had been called for snow removal. He did not know when he wrote it except that he did so the day she came to see him. He did not know if Respondent needed snow removal on the 17th or if it was immediately before her accident.

Mr. Reynolds testified that if Petitioner worked overtime with snow removal she would sign in and out and he would have put her overtime on the daily staff attendance report. Mr. Reynolds testified that, according to his paperwork, Petitioner was not working on February 17, 2014. Mr. Reynolds also testified that he was unaware of any information that would indicate the accident on February 18th didn't occur the way Petitioner described.

Petitioner's counsel then called Mr. Thomas Dodson on rebuttal. Mr. Dodson testified that in February 2014 he was temporarily assigned as a Storekeeper III. Mr. Dodson testified that storekeepers can be mandated to perform snow removal. Mr. Dodson testified that he and Petitioner were called to do snow removal at one time. Mr. Dodson testified that he and Petitioner shoveled snow almost all night. Mr. Dodson testified that Petitioner did not complain about her back at all when they shoveled snow together.

On cross-examination Mr. Dodson testified that he had no independent recollection as to when he and the Petitioner shoveled snow together. Mr. Dodson testified that when he worked overtime for the engineering department he would sign in on that department's sign-in sheets. Mr. Dodson reviewed Respondent's Exhibit 9 and testified that he had not signed the daily staff attendance report for the engineering department on February 17, 2014. Mr. Dodson testified that signing the sheet is something he would do to make sure he would be paid for his overtime.

Mr. Dodson agreed that if he had done snow removal on that day then he would have signed in on the attendance sheet. Mr. Dodson agreed that he did not work on February 17, 2014, as a Storekeeper III either because it was a holiday. Mr. Dodson testified that after he shoveled snow he felt awful and called in sick the following day.

Mr. Dodson testified that his supervisor at the time was Ms. Wooters, and that he trusted her to make sure his timesheets were correct.

Petitioner was then called as a rebuttal witness. Petitioner testified that she was called in to do snow removal on February 17, 2014. Petitioner testified that February 17, 2014, was a holiday and she was scheduled to be off work but was called in to shovel snow. Petitioner testified she had no idea why the timesheets reflected differently. Petitioner testified that she was paid overtime for shoveling snow. Petitioner testified when she left after shoveling snow that she was tired, but her back was not sore. Petitioner testified that she did not remember what time she left the facility after shoveling snow, but she did not get very much sleep.

On cross-examination Petitioner testified that she was certain that she performed snow removal on February 17, 2014. She testified that she was certain because she commented to different people how crazy it was that she slipped on ice and that was something she was taking care of the night before and missed. She also agreed that the 17th was a holiday and she wasn't working her normal job. When asked about her earlier testimony that she worked a full day on the 17th as a Storekeeper I but was now denying that, Petitioner explained that she thought she had performed her regular job that day but it was a year ago and just remembering what she ate two days earlier "was good." When asked how she could so clearly remember the snow removal but not working Petitioner testified that she remembered telling her co-worker how stupid she had been in that she slipped on something that she was taking care of the night before. When asked about the testimony of Mr. Reynolds and Ms. Wooters and the fact their documents show she didn't work, she had no explanation stating she didn't see any of those papers and doesn't do that part of the work. She agreed she would physically sign in on two different attendance sheets and didn't remember where she would have signed in on the 17th.

Petitioner testified that she was sure she was paid for her overtime, and that in order to get paid her overtime her attendance sheets would have to reflect the correct hours she worked. Petitioner agreed that if her attendance sheets did not show her as having worked overtime during that time period, she would not have gotten her overtime pay. Petitioner testified that Ms. Wooters has been doing her timesheets for years without issue. Petitioner testified that she did not think Mr. Reynolds would have incorrectly maintained the engineering department's timesheets or logs either.

The case was then continued so that the Arbitrator could obtain the record of the earlier proceedings in order to have a complete record to review. Proofs were formally closed on

September 21, 2016 in Urbana after the Arbitrator had received the official record of the case from Chicago.

The Arbitrator concludes:

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

Petitioner sustained an accident on February 18, 2014 that arose out of and in the course of her employment with Respondent. Petitioner slipped on ice while getting out of her car in Respondent's parking lot to enter the building and work.

The Arbitrator first addresses credibility concerns raised by Respondent. The Arbitrator finds that the new evidence presented when proofs were re-opened did not diminish Petitioner's overall credibility. Petitioner never contended that she injured herself on the 17th shoveling snow. Most significantly, no one testifying at the hearings ever disputed Petitioner's account of what occurred on February 18, 2014. Indeed, while not a part of the record, Respondent's proposed decision does not dispute "accident" on the basis of Petitioner's credibility. Rather, it focused on whether Petitioner's accident "arose out of" her employment.

In the Arbitrator's view, the evidence pertaining to whether or not Petitioner was working on February 17, 2014 is not relevant to the issue of accident. At the initial hearing in September of 2015 Ms. Shipley and Petitioner were asked about Petitioner's work activities on February 17, 2014 because Petitioner's attorney wished to address the weight or persuasiveness to be afforded to Dr. Robson's opinion that Petitioner had degenerative disc disease that was not causally related to her work accident. Petitioner testified that she had worked eight hours the day before shoveling snow. Ms. Shipley did not know for certain. It was only after the hearing that, "out of curiosity", she pursued the matter and determined Petitioner did not work on the 17th. Ultimately, additional evidence was heard on this issue. While Ms. Shipley testified that Petitioner had never before mentioned to her anything about working the night before shoveling snow, the Arbitrator does not believe Petitioner was under any obligation to do so as it was irrelevant to whether she had just sustained an accident on the morning of February 18, 2014.

Having considered all the evidence presented at the hearings, the Arbitrator finds that Petitioner did not work on February 17, 2014. Petitioner testified that she worked in the storeroom until 4:00 p.m. and was then sent for snow removal. The attendance sheets don't corroborate that testimony. The 17th was a holiday so she would not, and did not, work her regular day. Interestingly enough, she had taken off four hours on Friday, the 14th, as vacation (the 15th and 16th being her days off). Petitioner ultimately conceded that she didn't work her regular job on the 17th. Given the fact the attendance records don't show she worked her regular job on the 17th nor do they show she worked any overtime the Arbitrator finds it reasonable to conclude that Petitioner wasn't called in for snow removal. Petitioner went to the trouble to get a "statement" from Mr. Dodson that he recalled

working at snow removal with her "sometime prior to her work accident." However, he never said they did so the 17th. Petitioner also testified to telling a co-worker she felt stupid after falling because she had just been called in to remove snow before then. She could have presented that co-worker to corroborate her testimony but didn't. She also could have made the effort to corroborate her work activities on the 17th by showing evidence of payment of overtime wages.

While Petitioner did not work on the 17th, no evidence was presented by Respondent showing that she didn't work that day because of low back complaints or problems. Furthermore, no one testifying on Respondent's behalf disputed Petitioner's description of what occurred on the 18th. There was no dispute that Petitioner's accident occurred on Respondent's property. While Petitioner may have been on her way to the entrance of the building which was also frequented by the general public, she fell/nearly fell on Respondent's parking lot and not at the entrance. Furthermore, as an employee she frequented that entrance more often than the general public, especially at that hour of the day. Petitioner testified, without rebuttal, that she was going in to work early (confirmed by her attendance sheet) as she needed to get caught up with paper work as they were under staffed. Thus, the general public would not have been entering into the building as early as Petitioner was.

Slips and falls on an employer-provided lot when hazardous conditions are present are generally compensable. *See Mores-Harvey v. Indus. Comm'n*, 804 N.E.2d 1086 (Ill. App. 3rd Dist. 2004); *Archer Daniels Midland Co. v. Indus. Comm'n*, 437 N.E.2d 609 (Ill. 1982); *Hiram Walker & Sons, Inc. v. Indus. Comm'n*, 244 N.E.2d 179 (Ill. 1968); *Carr v. Indus. Comm'n*, 186 N.E.2d 280 (Ill. 1962); *De Hoyos v. Indus. Comm'n*, 185 N.E.2d 885 (Ill. 1962) (cases in which claimant fell in employer's ice-covered parking lot). In *Archer Daniels Midland Co. v. Indus. Comm'n*, 437 N.E.2d 609 (Ill. 1982), the Supreme Court specifically noted that, "Where the claimant's injury was sustained as a result of the condition of the employer's premises, this court has consistently approved compensation." *Id.* Also, injuries sustained on the employer's premises by an employee going to or from his actual employment by a customary or permitted way within a reasonable time before or after work are generally deemed to arise out of and in the course of employment. *USF Holland, Inc. v. Industrial Commission,* 829 N.E.2d 810 (Ill. App. 1st Dist. 2005); *Peel v. Indus. Comm'n*, 362 N.E.2d 332 (Ill. 1977); *Deal v. Indus. Comm'n*, 357 N.E.2d 541 (Ill. 1976); *Hiram Walker & Sons, Inc. v. Indus. Comm'n*, 244 N.E.2d 179 (Ill. 1968); *Chmelik v. Vana*, 201 N.E.2d 434 (Ill. 1964); *De Hoyos v. Indus. Comm'n*, 185 N.E.2d 885 (Ill. 1962).

Referencing areas traversed by both employees and members of the general public, the Appellate Court in *Springfield Urban League v. Illinois Workers' Comp. Comm'n* held that when injury to an employee takes place in an area that is a part of the employer's premises that is attendant with a special risk or hazard, the hazard becomes part of the employment and satisfies the "arising out of" requirement of the Act. *Springfield Urban League v. Illinois Workers' Comp. Comm'n*, 2013 IL App (4th) 120219WC, 990 N.E.2d 284, 291 citing *Litchfield Healthcare Center v. Industrial Comm'n,* 812 N.E.2d 401, 406 (5th Dist. 2004). In other words, a hazard on Respondent's premises,

even though it may be a neutral risk elsewhere, *becomes* a "risk incidental to employment." *See Material Service Corp., Division of General Dynamics v. Industrial Commission,* 292 N.E.2d 367 (when conditions of the parking lot were a contributing cause to employee's death, employer was liable even though employee was not engaged in any work activity). In so holding, the Court adopted the rationale set forth in Larson's Workers' Compensation Law which stated, "The rationale for awarding compensation is that the employer-provided parking lot is considered part of the employer's premises. *Mores-Harvey v. Indus. Comm'n*, 345 Ill.App.3d 1034, 1038, 804 N.E.2d 1086, 1090-91, 281 Ill.Dec. 791, 795-96).

Respondent attempts to escape liability by the fact that Petitioner parked and entered through the same doors visitors would utilize. The Court's ruling in *Mores-Harvey*, however, expressly found such an argument in and of itself to lack merit. "Whether a parking lot is used primarily by employees or by the general public, the proper inquiry is whether the employer maintains and provides the lot for its employees' use. If this is the case, then the lot constitutes part of the employer's premises." *Mores-Harvey v. Indus. Comm'n*, 345 Ill. App. 3d 1034, 1040, 804 N.E.2d 1086, 1092 (2004).

While Respondent may contend that at the time of her accident Petitioner was encountering a neutral risk and did so more frequently than the general public, it is pivotal to understand that the "neutral risk"/"general public" analysis utilized by the Court in *Caterpillar Tractor Co. v. Industrial Comm'n,* 129 Ill.2d 52, 133 Ill.Dec. 454, 541 N.E.2d 665 (1989), is only triggered in the absence of a clear hazard. *Mores-Harvey v. Indus. Comm'n*, 345 Ill. App. 3d 1034, 1039-40, 804 N.E.2d 1086, 1091 (2004). Petitioner fell when she slipped on ice located on Respondent's parking lot which was maintained and under its control. No evidence otherwise was presented. Respondent's icy parking lot constituted a hazardous condition. Thus the hazard, although neutral, became a "risk incidental to employment" by virtue of the fact that it existed on Respondent's premises.

Petitioner consistently reported to all of her medical providers that her pain began as a result of a "slip on ice" from which she caught herself and felt immediate pain. While one record suggests that she struck the ground as a result of her fall (the IME report of Dr. Robson), both Dr. Robson and Dr. Raskas agreed that the nuance of whether Petitioner caught herself or whether she fell made no difference in their causation opinions. (RX7, p.16; PX9, p.29, 30)

The Arbitrator finds that Petitioner met her burden of proof and established that she sustained an accident that arose out of and in the course of her employment with Respondent on February 18, 2014.

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

Petitioner's current condition of ill-being in her lumbar spine is causally related to her accident of February 18, 2014. In so concluding the Arbitrator relies upon a chain of events and the more persuasive testimony of Dr. Raskas over that of Dr. Robson.

One of the pivotal issues on this issue is whether Petitioner's low back was in general good health before her accident in 2014. In this regard the Arbitrator has considered whether Petitioner's untruthfulness about working on the 17th undermines her credibility regarding a lack of prior low back problems and, in turn, a chain of events analysis. While Petitioner testified to no prior low back pain or complaints before February 18, 2014 that testimony is potentially at odds with the history recorded by Dr. Young on February 20, 2014. At that time he noted a history of "recurrent self-limiting episodes" of low back pain. While Dr. Raskas noted a history of no "consistent prior low back pain" (allowing one to argue that she still may have had some episodic prior low back pain) no evidence of any treatment for any low back pain problems or complaints was presented by Respondent. Dr. Raskas treated Petitioner in 2008 for a cervical spine injury and testified, without rebuttal, that she had no lumbar spine complaints at that time. This issue was also discussed, at length, with Dr. Raskas, during his cross-examination when counsel for Respondent asked the doctor to explain to her how such a relatively young person in "relatively good health" could have sustained an injury as she had given the relatively "benign" nature of the accident itself. Thus, to some extent, counsel even acknowledged during Dr. Raska's deposition that Petitioner was in relatively good health prior to her accident. No evidence was presented that she was not working full duty for Respondent prior to the accident. Furthermore, both parties agree that as a Storekeeper I she was required to engage/assist with snow removal as needed. While she may not have been doing so on the evening of February 17, 2014 several witnesses agreed that she did, indeed, perform that activity as needed and had done so before February 18, 2014. Thus, prior to the accident she was working in a physically demanding job with no indication of limitation, restriction, or accommodation. Furthermore, Dr. Raskas was even asked to assume that Petitioner had prior back problems, including degenerative changes, and still he testified that it did not alter his opinion as he felt the accident would have then aggravated her condition. In the end, the Arbitrator finds Petitioner credible regarding her testimony concerning lack of prior back problems, especially given Respondent's inability to present any evidence to the contrary.

Both Dr. Raskas and Dr. Robson agreed that Petitioner's fall resulted, minimally, in a strain of her lumbar spine. While it is true that Dr. Raskas released Petitioner to return to work on a full duty basis on May 12, 2014 he did not release her at maximum medical improvement; rather, he noted her symptoms were "resolving" (not resolved) and that she was still experiencing lower back pain despite the resolution of her leg symptoms. Petitioner was then to return in four to six weeks which she did. She had also resumed full duty activity with Respondent. When she returned she was reporting further symptoms associated with that return to full duty activity and Dr. Raskas imposed restrictions and recommended further treatment. He would later again allow her to return to full duty work only to notice increasing symptoms. This full duty work may have included snow removal as Petitioner presented to the emergency room almost one year to the date of her accident

on February 17, 2015 reporting increased back pain after shoveling snow. Dr. Raskas persuasively explained his progressive course of conservative care and treatment and that Petitioner has never been asymptomatic or returned to her pre-accident condition. He explained that she has potentially two problems (her spine and her sacroiliac joint) but he wishes to focus on the spine first. Petitioner's 2014 showed a mild bulging annular disc for which Dr. Raskas has noted progressive worsening of her symptoms and condition. Dr. Robson did not consider Petitioner's ongoing work activities while remaining symptomatic as a possible source of her ongoing problems. As this has progressed so has the condition of her disc at L4-5 (and even L5-S1 as a small disc herniation was noted on her CT scan post discogram).

Dr. Raskas has identified two annular tears in Petitioner's low back which are manifesting themselves with chronic back and leg pain complaints. The doctor credibly explained how the resumption of work activities and the passage of time have increased Petitioner's symptoms and worsened her condition. The Arbitrator further notes that Dr. Robson never addressed the issue of whether he felt Petitioner had SI dysfunction. Furthermore, he acknowledged during his deposition that Petitioner did, indeed, have annular tears. He did not mention that, however, in his written report despite having evidence of them provided to him. He did not address whether Petitioner's condition and need for surgery was causally related to the tears and her work accident or the combination of the accident and attempts at full duty work. Additionally, he misread the 2015 CT discogram stating in his report that it did not show a herniated disc at L5-S1 when, in fact, the report reflects a small herniation being seen at that level. Dr. Raskas credibly testified that Petitioner's accident on February 18, 2014, either caused or aggravated her L4-5 and L5-S1 pathology. (PX9). Petitioner has never been pain free since the accident and there is nothing in the record showing that Petitioner had any difficulty working or performing her job duties on account of her low back prior to the accident on February 18, 2014.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

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

The Arbitrator finds that all of Petitioner's medical care has been reasonable and necessary. Dr. Raskas' approach to addressing Petitioner's complaints has been conservative and reasonable. Dr. Raskas first attempted to resolve Petitioner's condition with anti-inflammatory medication, bracing, and physical therapy. When these failed to resolve Petitioner's complaints, Dr. Raskas recommended injections. These also failed to provide Petitioner lasting relief. Each time Petitioner was released to full activity, her condition progressively worsened. Ultimately, Dr. Raskas had to place Petitioner off work and has recommended surgery as a last resort. He testified that Petitioner has not reached maximum medical improvement for her condition. (PX9, p.20)

The Arbitrator notes that Dr. Robson disagreed with Dr. Raskas' recommendations, but the Arbitrator finds his opinion and reasoning to be inconsistent and unsupported by the evidence. Dr. Robson premises his opinion on the notion that Petitioner that Petitioner merely suffered a strain as a result of the February 18, 2014 accident, and that Petitioner reached maximum medical improvement within a couple of months following the injury. (RX5, RX7, p.12) However, this is belied by his own observation that Petitioner's condition did not improve within the time frame during which a "strain" would resolve. (RX7, pp.12, 28, 29) He also acknowledged that there was no evidence in any of the records that Petitioner was malingering or exaggerating any of her symptoms. *Id.* at 32, 33. Additionally, Dr. Robson testified that he agreed with all of the conservative treatment Petitioner had, which included physical therapy, medications and injections. (RX7, p.11) However, the course of care which he agreed was reasonable and necessary extended far beyond the few months during which a "strain" would have resolved; Petitioner's course of conservative care spanned over a year. In short, even Dr. Robson admitted to belief that Petitioner did not reach maximum medical improvement when her "strain" should have resolved. The Arbitrator finds Dr. Raskas' opinion that Petitioner clearly had, and has, more than a strain going on to be more persuasive. (PX9, p.12)

Accordingly the Arbitrator relies on the recommendations of Dr. Raskas and finds that Petitioner has not reached maximum medical improvement and that she is entitled to prospective care.

Respondent is ordered to pay the medical bills contained in Petitioner's Group Exhibit 1 (totaling $7,020.00) and to authorize and pay for the surgical treatment recommended by Dr. Raskas if still deemed appropriate in light of the time that has passed since the initial hearing herein. Respondent shall have credit for any medical bills which have been paid through its group health coverage, but shall indemnify and hold Petitioner harmless from any claims arising out of the expenses for which it claims credit.

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

Petitioner claims entitlement to temporary total disability benefits from May 3, 2015, to the date of the hearing (September 9, 2015). Respondent did not dispute the dates of temporary total disability only liability for the benefits. Consistent with her liability determination herein, the Arbitrator awards Petitioner temporary total disability benefits for 27 1/7 weeks from Petitioner's period of disability from March 3, 2015, through September 9, 2015.

****

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

Kevin Mallie,

Petitioner,

17IWCC0497

vs.

NO: 15 WC 18152

Illinois Cement Company,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b)/8(a) 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 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 28, 2016, 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.

17IWCC0497

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 16 2017
o8/3/17
DLS/rm
046

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

17IWCC0497

MALLIE, KEVIN
Employee/Petitioner

Case# **15WC018152**

ILLINOIS CEMENT COMPANY
Employer/Respondent

On 11/28/2016, 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 0.60% 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:

2748 PERONA PETERLIN ANDREONI
GARY L PETERLIN
PO BOX 35
OGLERBY, IL 61348

1872 SPIEGEL & CAHILL PC
MILES P CAHILL
15 SPINNING WHEEL RD SUITE 107
HINSDALE, IL 60521

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8A

Kevin Mallie
Employee/Petitioner
v.
Illinois Cement Company
Employer/Respondent

Case # **15** WC **18152**
Consolidated cases: _____

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Carolyn Doherty**, Arbitrator of the Commission, in the city of **Ottawa**, on **October 31, 2016**. 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 **Respondent's Motion to Strike the Testimony of Dr. Perona**

FINDINGS

On the date of accident, **February 3, 2015**, 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 **$72,583.96**; the average weekly wage was **$1,395.85**.

On the date of accident, Petitioner was **58** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in the care and treatment of Petitioner's causally related condition pursuant to Sections 8 and 8.2 of the Act.

Respondent shall authorize and pay for the prospective surgery recommended by Dr. Perona and the attendant care pursuant to Sections 8 and 8.2 of the Act.

Respondent's Motion to Strike the testimony of Dr. Paul Perona is denied.

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

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

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

Carolyn M. DeCesy

Signature of Arbitrator

11/21/16

Date

NOV 28 2016

FINDINGS OF FACT

Petitioner, a 59 year old right hand dominant truck driver, testified that he has worked 26 years for Respondent, Illinois Cement Company, a mining operation. Petitioner testified that for the last 9 years he has been driving a double side semi dump truck hauling limestone boulders. The limestone is dropped in the truck via end loader at an off-site quarry and Petitioner drives the truck back to Respondent's plant for crushing. Petitioner works 4 10 hour days and 2 8 hours days per week. Specifically, Petitioner credibly testified that he reports to work at the cement plant, pre-trips his truck, and then drives the truck out to the road where he then drives 16 miles round trip. The truck has 10 speeds. If the truck is loaded, he is pulling 80,000 pounds in second gear. If the truck is unloaded, he drives in 3 to 4th gear.

Petitioner described the truck shifting requirements in detail at trial. He testified that he is required to shift the truck from 3rd to 10th gear on highways. He further testified that once off the highway he encounters 8 stop signs one way, 16 round trip, and he has to repeat the sequence of shifting gears. He further testified that he is also required to downshift during traffic. Once in the quarry, Petitioner must maneuver his truck around the other trucks, stopping and yielding for other trucks in the quarry. As such, he is required to stop and downshift several more times while in the quarry on rough quarry terrain. Petitioner testified that while in line at the quarry and at the plant, he had to "inch" the truck in a stop and go motion, which required a great amount of forceful shifting in the low gear range. Petitioner estimated that he shifts the truck 70 times per round trip and that he makes 15 rounds during a 10 hour shift. He estimated that he shifts approximately 700-1000 times per day.

At trial, Petitioner more specifically testified that he drove the same truck for 8 years until the truck was replaced in October of 2015. The truck Petitioner drove utilized a clutch break with a shift knob and rod (depicted PX 7a, 7b). Petitioner testified that for 40% of the time he drove his assigned truck, the clutch break was broken, resulting in the gears not meshing while manually shifting. This defect required the Petitioner to forcefully push forward and pull backward on the shifter until the gears "meshed" into place – especially when shifting in the lower gears. Petitioner testified that so much force was necessary to shift the gear that the rod depicted in 7b became bent over the course of Petitioner's use of the assigned truck. At the hearing, the Petitioner demonstrated the forceful pushing and pulling on the shift knob with impact on his right palm. He described keeping his right hand on the shift knob as it vibrated and shifted into gear. Petitioner testified that while pushing the shifter forward and backward he experienced pressure and pulling on his right palm.

Petitioner testified that he reported the clutch break defect several times and that he completed reports requesting repair. Petitioner subpoenaed these reports but they were reported lost and thus not produced at trial. Petitioner estimated that the truck was repaired only 40% of the time he drove the truck. Petitioner testified that he had a 15 minute lunch break but otherwise was required to be in the truck the entire shift.

Petitioner testified that he first noticed right hand problems in early 2014. He noticed that his right hand fell asleep at night and that he experienced right hand pins and needles all day while driving. On 2/3/15, the alleged manifestation date, Petitioner went to occupational health at

Illinois Valley Community Hospital as directed by Respondent. Petitioner reported "right middle finger pain that extends up into the right arm and right shoulder. Patient describes as a constant pain 10/10. Pain wakes pt up at night. Pt states he's been taking ibuprofen for pain. Pt states right middle finger is numb and feels like right hand is on fire. Right hand dominant." (PX5) The written history indicates "the patient states over the last year he has noted a throbbing pain located primarily in the right middle finger extending into the right hand and into the right forearm. He complains of associated numbness and tingling in the right middle finger as well as a weakened hand grip and a burning sensation in the palmar aspect of the right hand. ... The patient also complains of right shoulder discomfort that is aggravated with raising the shoulder above shoulder level. The patient has been employed at Illinois Cement for the last 8 years as a driver, stating that he has to "constantly shift." Prior to driving, he was employed for 16 years at Illinois Cement working high impact equipment." The right hand exam revealed tenderness with palpation over the right middle finger metacarpophalangeal joint. Arthritic nodes are noted to the DIP and PIP joints of all fingers on the right hand. Full finger range of motion. Tenderness with tight hand grasp. Palmer pain with palpation over the distal palmar crease at the middle finger. No nodule is noted. No triggering is noted. No thenar eminence atrophy." PX 5.

Right hand x-rays were ordered under a diagnosis of severe osteoarthritis, right hand paresthesia and right bicep tendonitis. The x-rays revealed "arthritic changes involving the right hand with evidence of degenerative osteoarthritis most severely affecting the second and third metacarpophalangeal joints with associated mild anterior subluxation and progression since prior study from 5/31/12." Records submitted by Respondent from Petitioner's primary physician contain the prior 5/31/12 right hand x-rays indicating degenerative changes about the second and third metacarpophalangeal joint. No evidence of acute bony trauma or bone destruction." RX 4. On 2/3/15, Petitioner was referred to an orthopedic specialist, Dr. Schlenker, and returned to work without restrictions.

Respondent presented a prepared Injury Report for Workers' Compensation to the Petitioner on February 15, 2015, which the Petitioner signed. (RX3) He attributes the right numbness, pain and tingling to "constant shifting of gears in truck 300+ times daily." (RX3) The injury was described as a "progressive injury" of which Petitioner had complained "on and off" for the last year.

Petitioner chose to see Dr. Perona on 3/4/15. Petitioner reported consistent hand and middle finger pain and numbness complaints and reported "no specific injury just repetitive work." He reported his pain worse at night. PX 4. He reported having the symptoms for 1 year. Petitioner was referred to a neurologist for EMG/NCV, Dr. Benavides. PX 4. On 4/30/15, following the EMG/NCV showing moderate right carpal tunnel syndrome, Petitioner was diagnosed with carpal tunnel syndrome of the right hand and Dr. Perona injected the right wrist directing Petitioner to follow up. On 5/14/15, Dr. Perona noted right hand pain and numbness with 3 days relief from the prior cortisone injection. Petitioner was again assessed with right carpal tunnel and a carpal tunnel release was scheduled pending work comp approval. Again, Petitioner was released to full duty work. PX 4. Petitioner saw Dr. Perona again on 1/28/16 and 2/16/16. Symptom worsening was noted at both visits as was exacerbation of the pain when working, grabbing and gripping and shifting the truck. PX 4. Surgery was again recommended and Petitioner was placed on Mobic. PX 4.

On 6/15/15, Petitioner presented for a Section 12 exam at Respondent's request with Dr. Vendor. PX 9. Petitioner described his work as a "quarry truck driver." Following an exam, Dr. Vendor diagnosed right carpal tunnel syndrome, degenerative arthritis of the index and middle fingers and possible flexor stenosing tenosynovitis. Dr. Vendor noted the carpal tunnel was confirmed by the electrodiagnostic study which explained "a portion" of Petitioner's complaints. Dr. Vendor noted that Petitioner described persistent shifting of a forceful nature with impact on the palm while driving the truck. Dr. Vendor stated that if he performed this activity persistently through the work day, "I would consider it a contribution to the development of carpal tunnel syndrome and flexor stenosing tenosynovitis. If it is performed on a more limited basis, such as doing more over the road driving, I would not consider that a contribution." He stated that the arthritis is not related to Petitioner's work activities. Dr. Vendor recommended the carpal tunnel release. PX 9.

Dr. Vendor authored an addendum report dated 8/20/15 after he reviewed a video supplied to him by Respondent. As documented in the addendum report, the video demonstrated a worker driving a truck for Respondent with very little force, effort or resistance applied to the gear shift. The video showed highway driving and did not show driving or shifting of the truck in the quarry. As the video did not depict significant forceful grasping and only intermittent shifting, Dr. Vendor opined that the work activities depicted in the video were not contributory to right carpal tunnel syndrome. PX 9.

Respondent did not present the video at trial or submit the video into evidence. The Arbitrator has therefore not seen the video. Petitioner testified at trial that he was previously shown the video. In response to Dr. Vendor's second report, Petitioner testified that the video depicts a newer truck and does not depict the truck that he drove for 8 years with the problematic clutch break. Petitioner pointed out that the depicted truck was empty resulting in no pull or drag while shifting and that the truck in the video was only driven on a smooth highway without depiction of the truck driving conditions involved with quarry driving. Lastly, Petitioner testified that the video showed the truck easily shifting which was not the case with the truck Petitioner drove which required Petitioner to forcefully "jam" the truck into gear.

Petitioner testified on cross exam that although his hand vibrated on the gear shift while driving, vibration was not the "main" problem. Petitioner testified that his symptoms arose from the "jamming" and pushing required to get the truck into gear. He further testified that he did not report his carpal tunnel as a "health" problem or impairment during his CDL license exam in August 2015. RX 4. He further testified that he has been driving the new truck for one year and that his right hand problems have not dissipated during this time. He continues to have pain in the right hand despite the fact that he no longer has to apply great pressure to the gear shift.

Currently, Petitioner has difficulty using his right hand to pick things up and to button his shirt. Petitioner has not lost time from work as a result of his condition. Petitioner is willing to undergo the recommended surgery for his right carpal tunnel.

Dr. Perona presented for evidence deposition on 2/23/16. PX 3. Dr. Perona practices in family orthopedics and is a board certified orthopedic surgeon. He regularly performs carpal tunnel surgery. He noted that Petitioner had right hand pain and numbness of the right middle finger

worse at night. Petitioner reported that he drove a semi truck which exacerbated his symptoms as did the repetitive work. After EMG/NCV testing, Dr. Perona diagnosed right carpal tunnel and Petitioner underwent a cortisone injection. Relief was temporary so Dr. Perona recommended a right carpal tunnel release surgery which remains his current recommendation.

Dr. Perona testified that Petitioner explained his job duties. When asked if any of Petitioner's job aspects might have an effect on Petitioner's condition of carpal tunnel, he testified, "Well, being a truck driver and being a big construction type of a truck, I would strongly feel that he would have exposure to excessive vibratory situations, in addition to the constant gripping and use of the hand." He testified that vibration worsens carpal tunnel symptoms. Dr. Perona opined that Petitioner work activities worsen his carpal tunnel. PX 3, p. 15.

On cross-exam, Dr. Perona testified that he was not provided with a video of Petitioner's work activities and thus did not review a video. PX 3, p. 20. He was asked "Is there any authoritative study or any federal report indicating that truck drivers who operate equipment such as Mr. Mallie are at risk of greater incidences of right side carpal tunnel?" to which he responded "none that I'm aware of." PX 3, p. 20. He was then asked, "Can you testify based upon a reasonable degree of medical and surgical certainty that Mr. Mallie was, in fact, exposed to a level of vibration that was a definitive cause of his carpal tunnel?" to which he responded "I would say that it would be my opinion that he would be exposed to enough vibratory, or enough vibration to exacerbate his carpal tunnel." PX 3, p. 21. He agreed that worsening symptoms at night is not unusual for carpal tunnel and that night worsening is usually the result of people sleeping on their hand in a bent position. PX 3, p. 21. He testified that such a sleep position is not a cause of the carpal tunnel but might make it symptomatic. PX 3, p. 22-23. He further testified that positioning of the hand on the stick shift in the truck would require the driver to have the wrist more flexed than extended but that he did not see any video depiction Petitioner in this position. PX 3, p. 23.

Dr. Perona further agreed that his patient questionnaire used to treat his carpal tunnel patients does not contain questions concerning vibration or the use of vibratory tools in order to identify hand and arm complaints. PX 3, p. 25. He testified that Petitioner told him that he had difficulty gripping which can be associated with arthritis but in Petitioner's case he considered Petitioner's hand weakness part of Petitioner's carpal tunnel. PX 3, pp. 25-26. Petitioner reported decreased sensation along the thumb, index and middle finger during his treatment. PX 3, p. 26. Dr. Perona was asked "Is there any indication that he had—or is there any authoritative study that indicates that the exposure of truck drivers using stick shifts of this type, is there any study that shows a link between that and the truck drivers? Is there any studies to that effect?" Dr. Perona responded, "Whether or not there is is irrelevant, as far as my opinion. I don't feel that because there wasn't a study that look specifically at truck drivers, you know, in varying situations--- I mean, if there was a study that looked at that, I'm sure that you could completely make that an irrelevant study given the fact that there are so many factors in the different types of trucks being driven, in the type of situations that people are put in. So to me, you keep bringing this up, whether or not there's any studies that associate truck driving with carpal tunnel I think to me is completely irrelevant, and I think it has no basis whatsoever in this type of a case." PX 3, pp. 30-31. When asked again if he reviewed a video of "the truck that he drove" Dr. Perona

responded, "I mean, a videotape means nothing to me if I don't see a videotape of that person during his work in the activity that he describes doing..." PX 3, p. 31.

Dr. Perona did not know that model of truck Petitioner drove. He testified that Petitioner told him he drove 8 to 12 hour shifts and that he was "...constantly going, pulling in and out of places, and he was constantly required to shift the truck." PX 3, p. 32. He testified that he did not know how many times per day Petitioner shifted. Furthermore, he did not document any use of the term "vibration of the truck" in his records. PX 3, p. 32-33. He indicated that he assumed vibratory exposure through his own observation of trucks.

Dr. Perona testified, "Well, I would say that the thing that he probably talked the most about or the thing that's documented in there was the repetitive use of the hand. I would say that he never really—we never really discussed the vibration or if he's – you know, if the thing chattered when he shifted. It was more the repetitive nature of it that he talked about. But I would – again, I mean, the vibration, you had asked me if there was anything that he could have been exposed to earlier, I'm pretty sure was the way that this whole vibration thing came into play. You'd asked me if there was anything that could have exposed him or caused or exacerbated the carpal tunnel, and I think that was one of the things that I felt could have exacerbated his symptoms." PX 3, p. 34. He further testified that vibration was due to the type of vehicle driven. Repetitive gripping in the palm of the hand would put direct pressure on the carpal tunnel and that "sometimes patients have a small muscle that crosses the carpal tunnel that trying to grip a ball or trying to shift a truck would cause you to basically decrease the size or the compartment with that position, in that position in that movement." PX 3, p. 35. He opined that Petitioner's shifting of the truck exacerbated Petitioner's carpal tunnel. PX 3, p. 36.

Respondent filed a motion to strike the testimony of Dr. Perona. Respondent argued his testimony should be stricken/not admitted because "he offered no medical or scientific basis for his conclusion that Petitioner's carpal tunnel syndrome was causally related to his work as a truck driver" and that as such his opinion/testimony was not sufficiently established to be considered generally accepted within the relevant medical community. RX 2. Respondent also asserts the fact that Dr. Perona did not see the video presented to Dr. Vendor in support of its position.

Petitioner responded to the motion asserting that Dr. Perona's testimony not subject to Respondent's Frye analysis in that his testimony is that of a treating physician giving an opinion as to the cause of the patient's condition and not based on or resulting in novel medical testimony. Petitioner's asserts the opinion is thus admissible with weight to be assigned by the fact finder.

CONCLUSIONS OF LAW

The above findings of fact are incorporated into the following conclusions of law.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT? F. WHETHER PETITIONER'S PRESENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY.

Based on the record in its entirety, including the credible, detailed and specific testimony of Petitioner regarding his job duties, the opinions of Petitioner's treating physician Dr. Perona and the original opinion of Dr. Vendor, the Arbitrator finds that Petitioner sustained repetitive trauma type injury to his right hand manifesting on 2/3/15 and causal connection for his current condition of ill-being in his right hand.

In so finding, the Arbitrator initially notes Petitioner's testimony regarding his job duties. Petitioner drove the same truck with clutch break issues for 8 years. Despite Petitioner's requests for repair of the truck, the truck remained defective 40% of the time during the 8 years Petitioner drove it until he was given a new truck in 2014. The truck problems required Petitioner to consistently and persistently apply pressure to the gear shift, "jamming" it into the lower gears multiple times per shift such that the shift rod developed a bend. Respondent's reliance on a video, not submitted into evidence at trial, and according to Petitioner, purportedly showing a driver other than Petitioner driving a different truck is not sufficient to rebut Petitioner's credible testimony regarding his job duties and the circumstances surrounding the use of his right hand and palm while driving. Petitioner credibly testified that this repetitive and forceful shifting activity resulted in pain, numbness and tingling in his right hand and middle finger which he reported to the first medical provider on 2/3/15 and relating the symptoms to his job duties.

The Arbitrator further notes that Dr. Vendor, Respondent's Section 12 examiner, initially agreed that Petitioner's described job duties caused or contributed to his diagnosed carpal tunnel. It was only after Dr. Vendor was presented with the video described and discredited above that his opinion changed to that of no causal connection. Therefore, the Arbitrator assigns greater weight to Dr. Vendor's first opinion of causal relationship as that being the more reliable opinion.

Lastly, the Arbitrator notes that Petitioner's treating physician Dr. Perona opined that Petitioner's carpal tunnel was caused and exacerbated by his repetitive gripping and shifting of the truck. The Arbitrator notes that this opinion was based on Petitioner's job description provided by Petitioner to Dr. Perona during the course of treatment. The Arbitrator further notes that Dr. Perona ultimately testified that Petitioner's condition was the result of the constant gripping and use of the hand in addition to any "vibratory" involvement with truck driving. PX 3, p. 15, 35-36. Accordingly, the Arbitrator finds that Petitioner sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent manifesting on 2/3/15 and that his current condition of ill-being remains causally related.

J. WHETHER RESPONDENT HAS PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY SERVICES. K. WHETHER THE PETITIONER IS ENTITLED TO ANY PROSPECTIVE MEDICAL CARE.

Based on the Arbitrator's findings on the issues of accident and causal connection, the Arbitrator further finds that Respondent shall pay Petitioner the reasonable, necessary and causally related medical expenses incurred in connection with the casually related right carpal tunnel condition pursuant to Sections 8 and 8.2 of the Act. Respondent shall receive credit for amounts paid, if any.

The Arbitrator further finds that based on the findings on the issues of accident and causal connection, Respondent shall authorize and pay for the recommended right carpal tunnel surgery and its attendant care pursuant to Sections 8 and 8.2 of the Act.

O. WHETHER THE EXPERT TESTIMONY OF DR. PERONA PERTAINING TO THE CAUSATION OF PETITIONER'S CARPAL TUNNEL SYNDROME SHOULD BE STRICKEN.

The Arbitrator denies Respondent's motion to strike the testimony of Dr. Perona on the basis of the Frye, Bernardoni or Durbin cases cited by Respondent is support of its motion.

Dr. Perona is the Petitioner's treating orthopedic surgeon. He examined and treated the Petitioner on several occasions and describes interviewing the Petitioner regarding the Petitioner's work duties. The medical records indicate that the Petitioner complained of pain while grabbing and shifting. (PX4) Dr. Perona demonstrates that he has an understanding of the shifting the Petitioner is required to do, and discusses the repetitive nature of this work duty. Dr. Perona states the Petitioner described the repetitive nature of the shifting. (PX3 p.34). Dr. Perona repeatedly testified to the repetitive shifting and grabbing putting direct pressure on the palm, and the resulting development of carpal tunnel syndrome. (PX3 p.35)

With this understanding of the Petitioner's work duties and the medical knowledge of the mechanics of carpal tunnel syndrome as a board certified orthopedic physician, Dr. Perona opines the right carpal tunnel syndrome was caused or exacerbated by the shifting of the truck. (PX3 p.35, 36). As noted above, Dr. Perona testified that any vibratory involvement was in addition to the repetitive forceful gripping used to shift.

Based on a review of Dr. Perona's testimony in its entirety, the Arbitrator finds that his opinion is that of a medical opinion offered by a treating physician based on job duties credibly described to him by Petitioner. His opinion is neither based on nor results in speculative medical theory and was obviously rendered in an area of medicine that is neither new nor novel. Respondent's motion to strike is denied. Dr. Perona's testimony is admitted and given the weight it merits as described above.

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

Kendall Pryor,

Petitioner,

17IWCC0498

vs.

NO: 15 WC 42651

Agricultural Services Company,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed January 19, 2017, 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 $50,000.00. 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 16 2017
o8/3/17
DLS/rm
046

Deborah L. Simpson

Deborah L. Simpson

David L. Gore

David L. Gore

Stephen J. Mathis

Stephen J. Mathis

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

17IWCC0498

PRYOR, KENDALL
Employee/Petitioner

Case# **15WC042651**

AGRICULTURAL SERVICES COMPANY
Employer/Respondent

On 1/19/2017, 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 0.60% 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
RICHARD E SALMI
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HEIGHT, IL 62208

2904 HENNESSY & ROACH PC
STEPHEN KLYCZYK
2501 CHATHAM RD SUITE 220
SPRINGFIELD, IL 62704

17IWCC0498

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)

Kendall Pryor
Employee/Petitioner

v.

Agricultural Services Company
Employer/Respondent

Case # **15** WC **42651**

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 **Springfield**, on **November 16, 2016**. 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, **10/26/15**, 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 in his left elbow/arm *is* causally related to the accident.

In the year preceding the injury, Petitioner earned **$9,423.68**; the average weekly wage was **$569.33**.

On the date of accident, Petitioner was **43** years of age, ***single*** with **2** dependent children.

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

Respondent shall be given a credit of **$3,062.86** for TTD, **$n/a** for TPD, **$n/a** for maintenance, and **$n/a** for other benefits, for a total credit of **$3,062.86**.

Respondent is entitled to a credit of **$0** for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services as set forth in **PX 13** with the exception of the following bills: (1) services with Dr. Shroff on November 9, 2015; (2) the SSM Health bill dated July 19, 2016 in the amount of $2,680.46; (3) the SSM Health bill of July 7, 2016 with a current balance of "0"; (4) the ER visit of February 17, 2016 billed on February 23, 2016 and amounting to $2,250.00; and (5) the ER visit at Decatur Memorial Hospital on April 7, 2016 in the amount of $1,314.25 and an electrocardiogram of the same date in the amount of $56.00. Said bills are awarded pursuant to the Medical Fee Schedule and pursuant to Sections 8(a) and 8.2 of the Act. Respondent shall receive credit for any bills that have been previously paid and shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving credit.

Respondent shall pay Petitioner temporary total disability benefits of **$379.55/week** for **27 5/7 weeks**, commencing **10/27/15 through1/6/16** (10 2/7 weeks), **1/27/16 through 4/11/16** (10 6/7 weeks), and **7/28/16 through 9/11/2016** (6 4/7 weeks), as provided in Section 8(b) of the Act. Respondent shall be given a credit of $3,062.86 for temporary total disability benefits that have been paid.

Respondent shall authorize and pay for the treatment to Petitioner's left elbow as recommended by Dr. Nathan Mall.

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

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

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

Signature of Arbitrator

January 12, 2017
Date

JAN 19 2017

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The Arbitrator finds:

According to medical records Petitioner presented to Dr. Rajendra Shroff, his primary care physician, on December 11, 2014. His complaints included cold-related symptoms and back pain. He was diagnosed with a backache due to degenerative joint disease (DJD), bronchitis and morbid obesity. Petitioner's Norco was refilled at that time. Petitioner was to return to see the doctor in four to five weeks. It does not appear that Petitioner followed up. (PX 5)

Petitioner again saw Dr. Shroff on April 9, 2015 for stress/anxiety after his parents had moved in. Dr. Shroff noted his complaints of back pain and joint pain and he was diagnosed with backache/DJD and morbid obesity. Restless leg syndrome was also noted. A prescription for Norco was given. Petitioner was to return in four to five weeks. It does not appear that he did. (PX 5)

Petitioner, a farm hand for Respondent, performed various duties including operating tractors and other equipment and other farm duties as needed. On October 26, 2015 Petitioner was working in the shop, washing a grain cart. On his way down from the cart, he slipped and fell, landing on concrete and striking his left elbow and landing on his back, injuring his neck, back and left elbow. Accident is not disputed. (PX 2, PX 3, AX 1)

The records of Kirby Medical Center dated October 26, 2015 note Petitioner had fallen off a trailer from approximately four feet, landing on his back on the ground, and hitting his head with no loss of consciousness. Petitioner complained of pain in his low neck, low back and left elbow. He reported a tingling sensation in his fingertips and toes; however, it was improving. (PX2) The Review of Systems noted left elbow pain, neck pain and back pain. Petitioner's physical examination revealed tenderness over the lower cervical spine in the midline, tenderness in the lower lumbar paraspinal musculature, pain with palpation of the left olecranon process, and pain with full extension of the left elbow. X-rays of Petitioner's cervical spine, lumbar spine and left elbow were read as revealing no acute fractures or dislocations; however, an avulsion type deformity on the anterior superior endplate of L4 was suspected although felt not to be acute. Petitioner recalled no previous injury. He was prescribed Norco and referred to his primary care physician for follow-up in 3-5 days. The discharge impression indicated status post fall, cervical strain, lumbar strain, left elbow contusion. (PX2)

That same day Petitioner presented to Decatur Memorial Hospital (DMH). Petitioner gave a consistent history of the accident and his work-up at Kirby. He reported that he was having problems with his back, left elbow and neck. He advised DMH of his work incident and his evaluation at Kirby Medical Center, including the fact that he had been told he had a fracture in his back but the doctor couldn't tell him where or whether it was old or new. Petitioner had not filled the prescription he'd been given and his pain was no better. According to the history provided by Petitioner, he had fallen about two feet landing

on his neck and back. The Triage Report stated Petitioner fell approximately eight feet and that he didn't hit his head but landed on his elbow. Petitioner had continued working after the fall. The records of DMH indicate complaints of worsening back pain, associated with falling and described as stabbing and aching. Physical exam revealed radial head and medial epicondyle tenderness of the left elbow and normal range of motion without swelling, edema, deformity or laceration. He was noted to have tenderness of the cervical, thoracic and lumbar regions but without any swelling, edema, deformity, laceration, pain, or spasm. CT scans of the head, cervical, thoracic and lumbar spines were read as revealing no acute findings, but a slight posterior subluxation L2-3 and L4-5 of uncertain age and etiology was noted. Petitioner's elbow x-ray showed degenerative changes of the proximal radial ulnar and ulnar trochlear articulation with degenerative osteophyte spurring. No joint effusion was noted. The ER physician consulted with Dr. Jacob Sams, an orthopedist, and, thereafter, Petitioner was fitted for a sling and a follow-up with Dr. Sams was recommended. (PX 3)

On November 6, 2015, Petitioner presented to Dr. Sams for his elbow injury. He described the pain as being located over the medial side of his elbow at the joint and radiating down his forearm on the volar aspect. He denied any numbness or tingling. Physical examination revealed tenderness to palpation over the medial epicondyle and pain with resisted wrist flexion at the medial epicondyle. Petitioner's range of motion was full with no instability to varus and valgus stressing. Dr. Sams felt Petitioner's physical exam showed symptoms related to medial epicondylitis or golfer's elbow and he recommended conservative care, including Mobic to address the inflammation. Petitioner was instructed to return in one month and he was released to return to work with no restrictions. (PX 4)

On November 9, 2015, Petitioner went to his family physician, Dr. Shroff for a regular check-up. Dr. Shroff's notes indicate PFSH of a "really bad head cold!" Dr. Shroff also noted Petitioner's complaints of back pain from his fall at work. The assessment was Pharyngitis/Bronchitis; allergic Rhinitis and Backache. He prescribed Amoxil, Claritin and Robitussin DM. Petitioner mentioned his work accident and was told to "follow up with his doctor for his W/C claim" and advised to return in 4-6 weeks. (PX 5)

Petitioner next saw Dr. Van Fleet on November 18, 2015 regarding his cervical pain. Dr. Van Fleet noted the history of Petitioner's fall from the grain cart. Petitioner's complaints included neck pain and pain in his arms, hands, and fingers bilaterally. Petitioner reported the pain was exacerbated by turning his head to the right and using either arm. Turning his head to the left or flexing/extending his head did not cause any problems. Petitioner had been taking Norco reporting that he had used up all his pills (20) and was taking Advil, as needed. On physical examination Petitioner ambulated with an abnormal gait. Petitioner's cervical range of motion was limited with no significant tenderness over the cervical paraspinal muscles but palpable discomfort across the thoracic spine. Cervical spine x-rays demonstrated a loss of the normal cervical lordosis but no evidence of any fractures. Lumbar spine x-rays showed multilevel degenerative changes. Dr. Van Fleet recommended physical therapy and took Petitioner off work for six weeks. According to the office note, copies of the visit were to be provided to "Work Comp – Ref Prov1-Encounter" and "Tracing Referring Doctor – Default PCP." (PX 6)

On referral by Dr. Van Fleet, Petitioner was seen at Phoenix Physical Therapy on December 3, 2015. His therapist was Julie Francis. The intake form indicated symptoms in Petitioner's neck, low back and left elbow. A pain drawing reflected same with no lower extremity radicular symptoms being noted. Petitioner told the therapist that he had been off work since the accident. He reported that his left hand occasionally felt like it was falling asleep. On examination he had tenderness over the left medial lateral epicondyles. He also reported walking "leisurely" outside the home approximately two miles per day and

that walking up inclines was uncomfortable. Petitioner was instructed in a home exercise program with stretches for lower trunk rotation, piriformis, lateral trunk reach, wrist flexion and extension. Modalities were applied consisting of ultrasound for the left elbow, IFC/moist heat for his neck and back, manual cervical traction which increased his pain, and kinesiotape for the left elbow. (PX 7)

Petitioner did not show up for his December 7, 2015 physical therapy appointment. Ms. Francis telephoned Petitioner to remind him his next appointment was on the 9th. Petitioner reported he had been very sore since the first appointment. (PX 7)

Petitioner followed up for physical therapy on December 9, 2015 complaining that he was very sore in his low back and legs. Petitioner had used roll-on ointment with no relief. He noted that taping his elbow had helped but it hurt to move his elbow. He thought he needed an MRI. Vicodin and Ibuprofen was being used with limited relief. Petitioner reported having increased pain two days after his last therapy session. It appears time was spent addressing performing therapy properly. (PX 7)

Petitioner returned to Dr. Sam's office on December 8, 2015 with the doctor noting no change in Petitioner's condition or treatment. He was told to return in one month. (PX 3)

Petitioner did not appear for therapy on December 11, 14 or 18th. (PX 7)

Petitioner signed his Application for Adjustment of Claim herein on December 18, 2015. (AX 2)

Petitioner was sent by Respondent for a Section 12 medical evaluation with Dr. Peter Mirkin on December 28, 2015. Dr. Mirkin had been asked to address Petitioner's neck, left elbow and lumbar spine. A written report followed. (RX 1 – dep. ex. 2 of Respondent) In his report Dr. Mirkin noted that Petitioner was injured on October 26, 2015 when he fell eight feet, struck his left elbow and "claimed" that he landed on his neck. He further "claimed" that he developed pain in his left elbow, left neck and low back. Petitioner told Dr. Mirkin that he was seen at the emergency room and underwent an extensive evaluation; however, he was unsatisfied with the evaluation and went to another emergency room where he underwent a similar evaluation. Petitioner told the doctor he had been treated with therapy, had been off work since the injury, and "really cannot do anything but does admit that he is able to drive." Petitioner's past medical history was summarized as "healthy." Petitioner was a heavy smoker and denied any neck or back problems before. His complaints on the day of the exam included: minimal neck discomfort; low back discomfort; and left medial elbow pain. (PX 1 – res. ex. 2, p. 1)

As part of the examination Dr. Mirkin had reviewed a job description for a farm laborer (Petitioner's job), the 10/26/15 ER visits at DMH and Kirby Medical Center, a record from Dr. Sams (11/6/15), multiple handwritten reports from Dr. Schroff (including a 4/4/15 note), physical therapy notes, and a surveillance video dated 11/18/15. Dr. Mirkin described the video as showing an adult male wearing a hat reaching into a car and bending forward, getting in and out of a vehicle, driving a vehicle, and walking with no signs of limp, discomfort, or antalgia. (RX 1, resp. ex. 2, pp. 1-2)

Dr. Mirkin's physical examination of Petitioner revealed an individual able to walk upright with no need for aides, no tenderness or spasm in his cervical spine, full range of motion of the cervical spine, no upper extremity atrophy, and intact deep tendon reflexes in the biceps, triceps, and brachioradialis. Petitioner's left elbow revealed full range of motion although Petitioner reported the medial aspect of his elbow was tender to palpation. Petitioner's elbow was stable to valgus and varus stress and there was no loss of motor function or motor mass in his elbow. Petitioner's lumbar spine reflected full range of

motion, the ability to heel and toe walk, squat and rise from a squat position, intact deep tendon reflexes, negative straight leg raise testing, and intact motor and sensory exams. Petitioner complained of pain when his back was palpated but no spasms were noted. Dr. Mirkin also had x-rays taken of Petitioner's neck, low back and left elbow. The cervical spine x-rays were noted to be normal, the lumbar spine x-ray showed very mild degenerative disease and the left elbow x-ray showed minimal degenerative disease. (RX 1, resp. ex. 2, pp. 2-3)

Dr. Mirkin was of the opinion that Petitioner might have sustained a contusion of strain of his neck, low back and left elbow. He felt Petitioner had minimal subjective symptoms and his objective examination was essentially normal. He felt Petitioner's treatment with therapy was appropriate and that Petitioner was "medically stationary", at maximum medical improvement and could return to full work duty if he so desired. (RX 1, res. ex. 2, p. 3)

Attached to Dr. Mirkin's report was a pain drawing completed by Petitioner at the time of the exam. Petitioner noted left elbow stabbing pain, low back stabbing pain, and bilateral burning in both thighs to just below the knees. (RX 1, res. ex. 2, p. 4)

Petitioner failed to appear for an appointment with Dr. Van Fleet scheduled for January 6, 2016. Dr. Van Fleet signed off on a full duty release at that time. (PX 6)

Subsequent to his evaluation by Dr. Mirkin, Petitioner presented to Dr. Nathan Mall on January 27, 2016 having been referred by his attorney. Dr. Mall recorded Petitioner's history of a fall off a grain cart when the wand of the power washer got tangled up and caught in his left foot. He reported some improvement in his neck and low back, but persistent left elbow pain and symptoms into the ulnar nerve. Physical examination revealed pain to palpation over Petitioner's lumbar spine, with pain to both flexion and extension. When turning his head to the left, symptoms into the trapezial area were noted. Dr. Mall noted also pain to palpation along the medial epicondyle, pain with resisted wrist flexion, mildly positive flexion compression test at the elbow and positive Tinel's at the elbow. X-rays of Petitioner's elbow were normal. Dr. Mall commented that Petitioner's lumbar spine x-ray revealed an anterior fracture at L4 and a possible compression fracture at L3. Dr. Mall diagnosed left elbow medial epicondylitis and a bone contusion following the accident of October 26, 2015. With regard to the elbow, the doctor recommended a cortisone injection into the medial epicondyle followed by physical therapy. He was also to wear an ulnar nerve night brace to help calm down the ulnar nerve symptoms. He wanted to see him back in four weeks for a reassessment and, if appropriate, an MRI would be ordered at that time. Dr. Mall felt Petitioner suffered a bone contusion at the time of the fall and possibly a tear of the medial epicondyle structures. He felt Petitioner could have contused his ulnar nerve when it was hit on the way down during the fall. The injection was given. On the Elbow/Wrist Rehabilitation Prescription form, Dr. Mall listed Petitioner's diagnoses as medial epicondylitis and cubital tunnel syndrome. (PX 8)

As for Petitioner's neck and low back, Dr. Mall referred Petitioner to Dr. Matthew Gornet or another cervical/lumbar spine specialist as there was "clear demonstration of trauma" with an acute fracture of the lumbar spine. Petitioner denied any prior falls or car accidents leading Dr. Mall to believe that the fall was the causative factor for the fracture seen on the x-rays. However, he wanted Dr. Gornet to evaluate both the low back and neck and felt an MRI would probably be required. (PX 8)

Dr. Mall imposed light duty restrictions as follows: avoid constant repetitive use of the left upper extremity; no push/pull greater than 2 pounds; and no lifting greater than 5 pounds. He referred Petitioner to Dr. Gornet. (PX 8)

On February 4, 2016 Petitioner went to physical therapy. A QuickDASH upper extremity assessment was performed. Petitioner reported his arm problem was interfering with his normal social activities "quite a bit" and he was "very limited" in his ability to work or perform regular daily activities. He described his pain as "severe" with mild tingling and weakness in his arm, shoulder and hand. He described moderate stiffness in his arm, shoulder or hand and moderate difficulty sleeping in the past week. Petitioner described no difficulty with the following activities: writing; turning a key; making a bed; changing a lightbulb overhead; walking or blowing dry his hair; washing his back; putting on a pullover sweater; using a knife to cut food; or engaging in recreational activities with little effort. He described mild difficulty with: pushing open a heavy door; placing an object on a shelf above his head; and performing heavy household chores. Petitioner reported moderate difficulty with opening a tight or new jar, carrying a shopping bag or briefcase, recreational activities requiring some force or impact with his arm or free movement of his arm. Finally, Petitioner claimed unable to carry a heavy object over ten lbs. (PX 12)

Petitioner failed to show up for physical therapy on February 19, 2016. (PX 12)

On March 7, 2016 Petitioner presented to Dr. Shroff regarding a sinus infection and a desire for lab work. His diagnoses included sinusitis, backache with degenerative disc disease, and chronic pain syndrome. (PX 5)

Petitioner underwent a lumbar spine MRI, per Dr. Mall, on March 8, 2016. It revealed a shallow central canal throughout, at least in part secondary to what appear to be congenitally shortened pedicles in concert with multi-level disc profile abnormalities, varying degrees of endplate spurring and facet arthropathy resulting in multi-level central canal stenosis and multi-level foraminal encroachment. (PX 8, PX 9, PX 10)

Petitioner underwent a cervical spine MRI, per Dr. Mall, on March 8, 2016. It revealed no focal disc profile abnormality, cord deformity, central canal or foraminal compromise. Alignment was anatomic and well maintained. (PX 8, PX 9, PX 10)

Petitioner's left elbow MRI taken March 8th, as requested by Dr. Mall, was read to show predominant abnormality related to tendinosis/tendinopathy at the common extensor tendon origin without tear or retraction. Mild elbow joint effusion was also present. (PX 8; PX 10)

Dr. Gornet saw Petitioner for evaluation on March 8, 2016 on referral by Dr. Mall for complaints of neck, mid and low back pain. Petitioner indicated that his current problem, "at least in its level of severity" began on October 26, 2015 when he fell off a grain cart. Petitioner told the doctor that he continued to work after the fall but that his pain became more severe so he went to Kirby Medical Center and the hospital in Decatur where CT scans were performed. Dr. Gornet noted that Petitioner had been referred to Dr. Van Fleet by the employer's insurance company and Dr. Van Fleet had ordered physical therapy and restrictions. According to Petitioner he had contacted Dr. Van Fleet's office to let them know he thought the therapy was making him worse and due to that he did not undergo any further therapy and was ultimately released by Dr. Van Fleet. Petitioner also reported that he had undergone an IME with Dr. Mirkin on December 28, 2015 who felt he had sustained a contusion or strain of his neck, low back and elbow but felt he could return to full duty and was at maximum medical improvement. Petitioner "readily" admitted to a history of low back pain in the past with the last episode of significance that he could recall occurring in 2010. Petitioner reported that his doctor maintained him on Hydrocodone four

tablets per day for months. Petitioner reported constant symptoms with his neck being worse than his low back and worse with reaching, pulling or fixed head positions. He denied significant arm pain but reported paresthesia and tingling in his arms. Petitioner reported that he had advised the physical therapy facility that the therapy was making him worse, so he did not obtain further therapy at that facility. Dr. Gornet reviewed the diagnostic films that had been done and saw no evidence of any cervical disc herniation or major pathology of significance. With regard to Petitioner's lumbar spine he noted annular tears at L1-2, L2-3, L4-5 and L5 – S1. Dr. Gornet did not feel Petitioner was at maximum medical improvement and noted "some confusion regarding his medical care and his compliance." He felt Petitioner was forthright, honest and showed no functional overlays. He thought Petitioner wished to return to work. Therefore, he felt it reasonable to modify Petitioner's physical therapy to avoid leg exercises which tended to place more mechanical loading on his lumbar spine. He also requested some mild modalities in his neck and upper back. Based upon the information in his possession, Dr. Gornet believed Petitioner's current symptoms were causally connected to his work injury and that he had aggravated his underlying condition in his low back and sustained a temporary strain in his neck. Since Petitioner presented with persistent back or neck pain after a reasonable course of conservative care, Dr. Gornet felt the MRIs were appropriate in order to help better understand Petitioner's problem. Dr. Gornet recommended six weeks of physical therapy and placed light duty restrictions on Petitioner with a full duty release for the neck and back beginning April 18, 2016. (PX 9)

On March 9, 2016 Petitioner dropped off the MRIs at Dr. Mall's office. The doctor reviewed the left elbow MRI noting it showed fluid around the ulnar nerve and some soft tissue swelling in the area of the medical epicondyle. He could not see a specific bone contusion noting it was still several months from his injury. He recommended an ulnar nerve night brace which was to be mailed to his home and he was to return in 3 -4 weeks to check on his progress. (PX 8)

Dr. Mirkin testified by deposition taken on March 25, 2016. (RX 1) Dr. Mirkin is a Board Certified Orthopedic Surgeon who treats patients for neck and back pain, including compression fractures in the lumbar spine. He very occasionally treats patients for medial epicondylitis, having treated less than five patients in the past year. He treats medial epicondylitis with bracing, injections and, if they need surgery, he will send them to somebody else. (RX 1, pp. 1 – 7)

Dr. Mirkin testified that he saw Petitioner for evaluation on December 28, 2015. He reviewed the medical records as detailed in his report along with a job description and he watched a surveillance video which appeared to depict Petitioner with no sign of pain. He performed a physical examination and took plain x-rays of Petitioner's cervical and lumbar spine. He also reviewed Petitioner's lumbar CT scan report which described slight subluxation, which Dr. Mirkin described, as very minimal. Dr. Mirkin did not see any compression fractures in Petitioner's lumbar spine on the x-rays he reviewed. Based upon the CT scan report and the x-ray films Dr. Mirkin saw no evidence of any fracture in Petitioner's spine. By history, Petitioner may have had a contusion or strain to the cervical spine, some degenerative disease in his lumbar spine and a contusion of the left elbow without fracture or dislocation. He did not recommend any additional treatment of the cervical spine, lumbar spine or left elbow. He did not recommend any activity restrictions from the work accident of October 26. He testified that his opinions were based upon an essentially normal exam, lack of disability by subjective complaints, and the video. He placed Petitioner at maximum medical improvement as of the date of his evaluation. (RX 1, pp. 8 – 14)

On cross-examination Dr. Mirkin agreed he could not comment on Petitioner's current condition of ill-being, having only seen him the one time in December of 2015. He acknowledged that the forms

completed by Petitioner for Dr. Mirkin's examination indicated throbbing pain in Petitioner's left elbow and pain in his lower and upper back. Dr. Mirkin testified that Petitioner complained of minimal neck discomfort, low back discomfort and left medial elbow pain. (RX 1, pp. 15 – 16)

Dr. Mirkin testified that Dr. Sams diagnosed golfer's elbow of the left upper extremity, but Dr. Mirkin has no idea whether golfer's elbow was the same as medial epicondylitis. He supposed it did. He agreed that epicondylitis can be caused or aggravated by striking an elbow on a hard surface and that golfer's elbow is usually due to golfing. (RX 1, pp. 19 – 20)

Dr. Mirkin could not recall how long the video was. He didn't ask Petitioner to confirm it was him in the video nor did he discuss the video with Petitioner. The doctor acknowledged that while the video showed a person walking normally that wouldn't be inconsistent with an injury to one's back muscles but it would be with a compression fracture. He agreed that one can have a normal gait and musculoskeletal injury. He further testified that people with a backache often find getting in and out of vehicles difficult and he saw no evidence of that on the video. (RX 1, pp. 21 – 25)

Dr. Mirkin agreed that Petitioner continued to report symptoms in his cervical and lumbar spines when seen for evaluation. Dr. Mirkin did not find any indication of symptom magnification. Dr. Mirkin agreed it is important to strengthen the cervical and lumbar musculature as part of an appropriate rehabilitation program. He agreed that Petitioner's traumatic accident could cause strains, sprains, and aggravate degenerative disc disease. (RX 1, pp. 25-26)

Dr. Mirkin agreed that Petitioner reported tenderness to palpation of his elbow and he believed that was a partially objective finding. He agreed it can be appropriate for a physician to recommend additional diagnostic testing where a patient continues to describe symptoms from a discrete trauma. In regard to the elbow, he agreed that diagnostic evidence of fluid can be an objective finding of pathology and that MRI evidence of soft tissue swelling is also an objective finding of pathology. RX 1, pp. 27-28)

On redirect examination Dr. Mirkin recalled Petitioner's statement that, when examined, he was unable to do anything. His examination and testing and records didn't corroborate that statement. On additional cross-examination Dr. Mirkin further testified that he also didn't think Petitioner's statement that he had no prior back problems was true. (RX 1, pp. 31-33)

On March 29, 2016, Petitioner followed up with Dr. Mall for his left elbow. Dr. Mall noted that Petitioner remained symptomatic with his ulnar nerve and medial epicondyle. Physical examination continued to reveal pain to palpation of the ulnar nerve, pain over the medial epicondyle, a positive flexion compression test at the elbow and a positive Tinel's at the left elbow. Petitioner had still not received his ulnar nerve night brace. Dr. Mall continued to recommend the ulnar nerve night brace and he also recommended an EMG nerve conduction study. He continued Petitioner's light duty restrictions for the left elbow. (PX 8)

On April 11, 2016, Dr. Mall lifted the work restrictions and placed Petitioner at full duty. (PX 8)

In April of 2016 Petitioner began working for ADM R & R Contracting as a concrete laborer.

On June 20, 2016, Dr. Daniel Phillips performed nerve conduction studies at the request of Dr. Mall. Petitioner reported falling in October of 2015 and striking his left elbow in the process followed by sharp throbbing aching medial elbow pain with intermittent numbness affecting his middle and ring

fingers and, occasionally, the index finger. Petitioner did not describe any neck or radicular pain. His right upper extremity was completely asymptomatic. Petitioner had last been checked for diabetes approximately one year earlier. On examination, Dr. Phillips noted tenderness over the left medial epicondyles on the common flexor tendon which reduplicates his left elbow pain. He noted right greater than left ulnar neuropathies in the context of a general decrease in conduction velocities and recommended Petitioner see his family physician to have his blood sugars checked as his right side appeared worse than the left side suggesting a possible underlying neuropathy as might be seen with hyperglycemia. Dr. Philips noted Petitioner's left elbow pain was duplicated with maneuvers for medial epicondylitis. (PX 11; PX 8)

Petitioner underwent blood work at SSM Health on June 29, 2016. The test revealed a glucose level of 98 with a reference range of 70-125 as normal and no flag indicating an abnormal test result. (PX12) HbB A1C from the same date revealed a value of 5.3 in a reference range of 4.2 – 5.8%, again with no flag to indicate an abnormal finding. (PX12)

On July 13, 2016 Petitioner telephoned Dr. Mall's office regarding his elbow complaints after the EMG/nerve conduction study. Petitioner reported seeing his primary care doctor per Dr. Phillips' request for evaluation of any underlying nerve issues. Petitioner reported normal blood work although Dr. Mall had not seen the studies himself. Petitioner reported ongoing pain on the medial aspect of his elbow and pain when trying to grip any objects or use his left arm to pick anything up. Petitioner also reported numbness in his ulnar distribution with some numbness into the index and middle finger as well. Dr. Mall noted that Petitioner was having some difficulty with finances and it was very financially stressful for him to get into the doctor's office. Dr. Mall noted Petitioner's medial epicondylitis and cubital tunnel syndrome were not getting better with conservative measures and the EMG had shown some ulnar nerve dysfunction of the elbow. He felt Petitioner needed a left elbow debridement of the medial epicondyle and a submuscular ulnar nerve transposition. They agreed to further address his carpal tunnel syndrome when Petitioner could make it back into the office. (PX 8)

On July 14, 2016 Petitioner was admitted to St. Mary's in Centralia for abdominal flank pain and possible pyelonephritis or a urinary tract infection. His diagnoses included chronic back pain for which he was on medication, hypertension, and morbid obesity. While in the hospital Petitioner showed no signs of neck pain nor were any such complaints noted. A CT scan of his abdomen showed a mildly descended urinary bladder and mild bladder wall thickening, minimal perinephric stranding indicating possible pyelonephritis, more on the left than the right and possible cystitis and nephritis. Glucose testing performed while there was also in the normal range at 111. By July 15, 2016 Petitioner was feeling better and he was discharged. (PX 12)

On July 28, 2016, Petitioner followed up with Dr. Mall who noted difficulty in getting Petitioner back into his office due to transportation issues. Petitioner remained symptomatic with the left elbow into the ulnar nerve distribution with some occasional numbness into his index and long fingers. Physical exam findings include positive flexion compression and positive Tinel's of the left elbow. Petitioner's diagnoses included medial epicondylitis, ulnar nerve compression, and left carpal tunnel syndrome. Dr. Mall concluded Petitioner had failed conservative treatment and recommended a left cubital decompression with ulnar nerve transposition and a left carpal tunnel release. He imposed light duty restrictions for Petitioner's left upper extremity. (PX 8)

Dr. Nathan Mall, a Board Certified Orthopedic Surgeon, testified on behalf of Petitioner by deposition taken on September 20, 2016. (PX1) Dr. Mall testified that he specializes in Sports Medicine with a focus on the shoulder and elbow. (PX 1, p. 4)

Dr. Mall began treating Petitioner on January 27, 2016, at which time Petitioner told him about his October 26, 2015 accident and how the power washer wand got tangled up in his left foot causing him to fall approximately six feet during which time he hit the inside of his left elbow on a bracket. Dr. Mall testified about the treatment Petitioner had received up to that point along with his complaints and physical examination all of which was consistent with what was recorded in his office notes. Based upon his examination, together with Petitioner's complaints, Dr. Mall's major concern was the inside of Petitioner's elbow which suggested left medial epicondylitis and a bone contusion. The doctor testified that while his notes did not discuss a diagnosis of left cubital tunnel syndrome, he also felt Petitioner had signs of it at that time. (PX1, pp.4-9) Dr. Mall testified that he recommended an ulnar nerve night brace, therapy, and anti-inflammatories as well as an injection. (PX 1, pp. 10-11)

Dr. Mall further testified that when he initially saw Petitioner, Petitioner also voiced neck and back complaints for which he referred him to a spine doctor for further evaluation. (PX 1, p. 11)

Dr. Mall testified that he felt Petitioner's accident at work was the cause of Petitioner's elbow condition, including both the contusion and the medial epicondylitis. He recommended work restrictions to prevent worsening of the condition and to try and reduce any irritation. Dr. Mall also testified that he ordered MRIs of Petitioner's left elbow, neck, and low back. He felt Petitioner's elbow MRI revealed some swelling in the area of the medial epicondyle and some fluid around the ulnar nerve consistent with irritation/inflammation. He did not see a bone contusion but since it was several months out from the accident it might have resolved by then. He continued to recommend the ulnar nerve brace for which they had some trouble actually getting it to him but eventually they did. (PX 1, pp. 11 -1 4)

Dr. Mall further testified that he reviewed a surveillance video and prior treatment records. (PX 1, p. 14)

Dr. Mall testified that his next visit with Petitioner was on March 29, 2016 at which time his office provided the night brace to Petitioner as he had never received it. Petitioner's exam was unchanged and there were no changes in restrictions or treatment at that point. (PX 1, pp. 14-16)

Dr. Mall testified that he later received a call from Petitioner stating that he wasn't really getting any better but he wanted to be released back to full duty work for he could look for a job. Dr. Mall released him. (PX 1, pp. 16-17)

Dr. Mall further testified that he later saw Petitioner again, he was no better, and the doctor recommended a nerve conduction study to better analyze the ulnar nerve. According to the doctor, that testing demonstrated some compression of the nerve at the elbow but it also showed some findings with regard to the median nerve and slowing of the right elbow. However, Petitioner wasn't complaining of any right upper extremity symptoms so he didn't recommend anything for the right arm as he treats the patient and his symptoms and not the nerve conduction study results. Since Petitioner had also mentioned some symptoms going into his long and index fingers the doctor wanted further evaluation for carpal tunnel syndrome. By the July 28, 2016 visit Petitioner had a positive flexion compression test but a negative Tinel's on the left wrist. (PX 1, pp. 17 – 19, 28-30)

Dr. Mall also testified that he spoke with Petitioner on July 13, 2016 at which time Petitioner told him that there had been some concerns for hypoglycemia or diabetes when Dr. Phillips did the nerve conduction study so Petitioner told him he had gone to his primary care doctor and undergone blood work which turned out to be normal. Dr. Mall wanted him to come back in to see him as Petitioner represented that he was still symptomatic and Petitioner did so on July 28th at which time he still had medial sided elbow pain, pain with gripping and grabbing, numbness into the ulnar distribution and occasional numbness into the long and index fingers. His examination was consistent with left medial epicondylitis, left cubital tunnel syndrome and some mild left carpal tunnel syndrome. Dr. Mall opined that Petitioner's left carpal tunnel syndrome was not causally related to the work accident. (PX 1, pp. 19 - 21)

Dr. Mall testified that he has recommended that Petitioner undergo surgery for his left elbow (a medial epicondyle debridement and submuscular ulnar nerve transposition) and that while Petitioner is under anesthesia the doctor might as well do a carpal tunnel release but that would not be under workers' compensation. In the interim, the doctor has continued to impose work restrictions. Dr. Mall also testified that Petitioner is not yet at maximum medical improvement with regard to his elbow. (PX 1, pp. 21-24) Dr. Mall explained that the surgery will address Petitioner's persistent symptoms as it is unlikely that Petitioner's nerve function will come back without further intervention. According to Dr. Mall, Petitioner has failed conservative treatment, the night brace, anti-inflammatories, physical therapy and injection. (PX 1, pp. 23-24) He felt all of Petitioner's treatment to date was due to the work accident. (PX 1, p. 25)

On cross-examination Dr. Mall testified that he did not bill for reviewing Dr. Mirkin's report or the surveillance video. He further testified that he released Petitioner to return to full duty work on April 11, 2016 but he didn't remember what kind of work Petitioner wanted to resume. The doctor also testified that Petitioner was referred to him by his attorneys and that the doctor has seen other clients of Petitioner's attorneys previously but it would be less than one percent. (PX 1, pp. 25 – 27)

Dr. Mall testified that whether Petitioner fell two or four feet wouldn't matter as the significant part of the accident was that he struck his elbow on something. (PX 1, p. 27) Dr. Mall was asked if he read Dr. Phillip's report to suggest that any neuropathies or neurological problems Petitioner had in his upper extremities could be related to a diabetic condition and the doctor indicated he did not read the report that way. He felt the doctor was noting he saw evidence of changes in Petitioner's nerves and was recommending further evaluation as if he was found to not have diabetes then that would rule out diabetes as the reason the nerves looked that way. Dr. Mall was also asked if he agreed that Dr. Phillips' report says nothing about any nerve compressions and the doctor responded that Dr. Phillips described neuropathies across the carpal tunnel and cubital tunnel which would mean there was a decrease in conduction at those spots which, in turn, would mean there's some compression there. If the neuropathy was related to blood sugar issues, Dr. Mall felt Petitioner would have symptoms in all of his nerves but he's not. Petitioner has only been symptomatic on the left upper extremity. He further explained that most people with diabetic peripheral neuropathy have numbness in their feet and describe the numbness as though they are wearing a glove or bootie and Petitioner has never mentioned anything like that. While he didn't physically see any test results ruling out diabetes, Petitioner advised him of same. (PX 1, pp. 27-32)

Dr. Mall also testified that Dr. Phillips, to whom he refers many patients, generally doesn't note whether a patient has a specific syndrome but he has on occasion. However, he does not consider it definitive if Dr. Phillips says someone doesn't have cubital tunnel syndrome so it must be a diabetic peripheral neuropathy. He further acknowledged that he has seen Dr. Phillips' reports reference a compression of a particular nerve. (PX 1, pp. 32-37) Dr. Mall was asked, based upon the assumption that

Petitioner's neuropathy in his left upper extremity was solely related to a diabetic condition, if surgery to the nerve would not be beneficial and the doctor testified, "That's actually false as well." He then testified that there are several studies showing nerve decompression stemming from diabetes can benefit the nerve. (PX 1, pp. 37-38)

On redirect examination Dr. Mall testified that he has no reason to believe Petitioner's elbow condition or the treatment he is recommending is related to a diabetic condition. His opinion on causation between Petitioner's elbow condition and his work accident remained unchanged despite any issues raised by Respondent's attorney regarding diabetes. On further cross-examination Dr. Mall acknowledged that he doesn't treat patients for diabetes. (PX 1, pp. 38 – 39)

Petitioner's case proceeded to arbitration on November 16, 2016. Petitioner was the sole witness testifying at the 19(b) hearing. The disputed issues were causal connection, medical bills, temporary total disability benefits, and prospective medical care.

Petitioner testified that he is 44 years of age. As of October 26, 2015 he was employed by Respondent as a farm hand. His duties included running the tractor, cleaning equipment, working in the shop, mowing, and weed eating. On October 26, 2015 Petitioner was working in the shop washing a grain cart with a power washer when he slipped off the third step while coming down and landed on his back, from his neck to his feet. He also hit his left elbow going down. Petitioner testified that he was then sent to Kirby Medical Center by his boss where he was given a quick check-up. Feeling that he needed better treatment, Petitioner then presented to the emergency room at Decatur Memorial Hospital.

Petitioner was asked if he had ever had any prior low back problems and he acknowledged that he had – "aches and pains." He testified that the symptoms he had after the accident were different than any he had experienced before as the pain was more consistent and went down his leg. Petitioner denied any prior elbow problems.

Petitioner testified that the emergency room doctor referred him to Dr. Sams for his back and elbow but Dr. Sams only looked at his elbow. He further testified that Dr. Sams referred him to Dr. Van Fleet who ordered physical therapy. Petitioner testified that he had "issues" with the therapist (Julie Francis) who made him do exercises despite the fact that they bothered him. He further testified that she assured him she wouldn't do it anymore but, nevertheless, she did so telling him that it shouldn't bother him.

Petitioner acknowledged an IME with Dr. Mirkin in December of 2015 and that, thereafter, he went to Dr. Mall for his elbow and Dr. Gornet for his neck and back. Petitioner explained that Dr. Mall referred him to Dr. Gornet who ordered therapy for his neck and back.

Petitioner testified that he has continued to see Dr. Mall for his elbow and that the doctor has recommended that he undergo surgery. He acknowledged undergoing nerve studies with Dr. Phillips and lab work for diabetes. Petitioner testified that he does not take any medication for diabetes.

Petitioner testified that Dr. Mall periodically had him working under light duty restrictions but, at his request, he was released by him to full duty on April 11, 2016 at his request because he had no income and had just lost his car. Petitioner testified that he subsequently found work and has worked despite ongoing problems.

Petitioner testified to seeing Dr. Mall in July of 2016. He was on full duty as of September 12, 2016. Petitioner is currently working for Loepker Farms. Petitioner testified that he still has problems with his elbow including pain in his joint going down his hand, problems with extension, and he can't hold a bow with his left hand for bow hunting.

Petitioner testified that some of his bills had been paid but then authorization stopped.

On cross-examination Petitioner testified that in April of 2016 he began working for ADM R & R Contracting on a concrete labor crew. Petitioner testified that he worked outside forming pads and foundation for light poles and basically ran the back hoe. He denied pouring or shoveling any concrete. He would get tools ready and take bolts and wedges out after the concrete was poured. He also acknowledged that he still works for Loepker Farms driving tractors and fertilizer trucks.

Petitioner acknowledged seeing his family doctor, Dr. Shroff, on November 9, 2015 for a respiratory problem and mentioning his back pain. The doctor took him off work until November 18, 2015.

On redirect examination Petitioner testified that he was still having problems while working for ADM and told his foreman who gave him light duty. He also testified that while working at Loepker Farms he notices that his arm hurts every day and he works within his restrictions and if it hurts, he lets someone know. Petitioner could not recall when he stopped working for ADM. He thought he was there about 1 – 2 months and he quit because he was having problems with the foreman and was laid off.

Petitioner's medical bills are contained in PX 13.

Petitioner testified that as part of the additional work-up for his left elbow, Dr. Phillips referred him for lab testing to rule out diabetes. Petitioner clarified that he had never been prescribed any treatment for diabetes previously and has not been prescribed any prescription medications for diabetes.

The Arbitrator concludes:

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

Petitioner's current condition of ill-being in his left elbow/arm is causally connected to his undisputed accident. This conclusion is based upon a chain of events, Petitioner's testimony, medical treatment records, and the more persuasive opinion of Dr. Mall over that of Dr. Mirkin. It is undisputed that Petitioner struck his left elbow when he fell. This history was reported to multiple providers and Petitioner's further undisputed testimony is that he had no history of left elbow symptoms prior to the present accident. Petitioner credibly testified that his left elbow symptoms have never resolved from the time of the work accident through the date of the 19(b) hearing.

Dr. Mall has persuasively testified and opined that Petitioner's condition of ill-being in his left elbow/arm is causally related to the work accident. He also persuasively and credibly testified that Petitioner's left carpal tunnel syndrome is unrelated to the work accident. The opinions of Dr. Mirkin are less persuasive than those of Dr. Mall given that Dr. Mirkin had less information available to review. Furthermore, at the time of the examination with Dr. Mirkin, he was not provided with all of Petitioner's medical records (such as Dr. Van Fleet's office note of December 8, 2015 or any records of Dr. Sams).

Dr. Mirkin never discussed performing a Tinel's or compression test on Petitioner's left upper extremity nor was same mentioned in his report. Thus, it appears that his examination of Petitioner's left upper extremity was not as extensive as that of Dr. Mall. Dr. Mirkin further acknowledged that he refers his medial epicondylitis patients out should surgery be necessary. Dr. Mall performs such surgeries. Thus, Dr. Mall appears to have more experience in this area than Dr. Mirkin.

While Respondent may contend that Petitioner's left elbow condition is due to an alleged diabetic neuropathy, it appears that a diagnosis of diabetes has been ruled out by lab work, the results of which were a part of the record. Furthermore, Dr. Mall was questioned at length about the possible role of diabetes in Petitioner's case and his answers and testimony negating same was persuasive.

While Petitioner has established the requisite causal connection regarding the work accident and his left elbow condition of ill-being, Petitioner failed to prove that any current condition of ill-being in his right upper extremity, neck, and low back are causally connected to his undisputed work accident.

Petitioner sustained an injury to his neck, low back and left elbow when he fell on October 26, 2015; however, none of the evidence in the record indicates an injury to his right upper extremity at the time of the fall. While Petitioner's medical records contain periodic references to right upper extremity complaints, it does not appear that Petitioner injured his right upper extremity in the work accident nor has any doctor opined that any such right arm complaints were causally related to the work accident.

Regarding Petitioner's neck and low back pain complaints, the Arbitrator finds that Petitioner has failed to prove ongoing causation since April 18, 2016. Dr. Van Fleet treated Petitioner for his neck and low back complaints, prescribed therapy, and released Petitioner to full duty on January 6, 2016 when Petitioner failed to appear for his scheduled appointment. Dr. Mirkin examined Petitioner on December 28, 2015, felt Petitioner had sustained neck and low back sprains/strains, believed Petitioner had minimal subjective symptoms and a normal objective examination and felt Petitioner could return to work on a full duty basis. If one looks at the pain drawing completed by Petitioner at the time of the examination with Dr. Mirkin one sees that Petitioner identified no neck symptoms or complaints. Petitioner also denied to Dr. Mirkin that he had any prior neck or back problems before his work accident and Dr. Mirkin was suspicious of that history, at best. Dr. Mall's opinion regarding a possible back fractures and Petitioner's accident is unpersuasive. Dr. Mall is not a back specialist which is why he referred Petitioner to Dr. Gornet who is. Dr. Gornet never diagnosed Petitioner with a fracture. Dr. Mirkin did not either.

Dr. Gornet then examined Petitioner on March 8, 2016 and felt Petitioner had sustained a temporary strain in his neck, had low back complaints related to the accident, recommended physical therapy and light duty restrictions until April 18, 2016 when he could resume full duty work. It does not appear that Petitioner followed through with the therapy and he has not returned to see Dr. Gornet since that initial examination. At the arbitration hearing Petitioner did not testify to any ongoing low back or neck issues nor did he ask for any prospective medical care regarding his low back or neck. Thus, the Arbitrator finds that Petitioner did sustain neck and low back strains/sprains as a result of his work accident; however, he reached maximum medical improvement for those conditions as of April 18, 2016 when he was released to full duty work by Dr. Gornet.

The Arbitrator further notes that Dr. Gornet's causation opinion regarding Petitioner's low back and neck is not persuasive. Dr. Gornet based his opinion on the information he had been provided by Petitioner on the date of the examination. Dr. Gornet did not independently acquire and review Petitioner's medical treatment records. While Dr. Gornet was aware that Petitioner had pre-existing low

back symptoms and problems, it was his understanding, based upon Petitioner's representation to him, that Petitioner's last problem with his low back occurred in 2010. That is not correct as Dr. Shroff's records show back complaints and symptoms in 2014 and early 2015 for which he was being prescribed Norco.

Petitioner has been able to work as a concrete laborer and farm hand since April of 2016. While he credibly testified to ongoing symptoms in his left elbow while working he didn't identify any neck or low back problems while so employed or at the time of arbitration. Petitioner's neck and low back strains/sprains have resolved; his left elbow condition has not.

Issue **J. Medical Bills.**

Petitioner is awarded the medical bills found in PX 13 with the exception of the following bills: (1) services with Dr. Shroff on November 9, 2015; (2)the SSM Health bill dated July 19, 2016 in the amount of $2,680.46; (3) the SSM Health bill of July 7, 2016 with a current balance of "0"; (4) the ER visit of February 17, 2016 billed on February 23, 2016 and amounting to $2,250.00; and (5) the ER visit at Decatur Memorial Hospital on April 7, 2016 in the amount of $1,314.25 and an electrocardiogram of the same date in the amount of $56.00. The foregoing bills were incurred for conditions unrelated to the claimed injury and accident.

As for the remaining bills, they are awarded as they fall within Petitioner's two choices of physicians. Petitioner first reported to Kirby Medical Center on the date of his accident for emergency medical treatment. The record details that he was evaluated for injuries sustained in his work accident. Respondent is responsible for payment of the outstanding charges from this facility.

Petitioner then chose to seek out treatment at Decatur Memorial Hospital, where the medical records detail further evaluation and treatment for the injuries sustained in the work accident. This constitutes his first choice. Respondent is responsible for the charges of DMH.

While at Decatur Memorial Hospital Petitioner was referred for treatment of his elbow injury to Dr. Sams who oversaw initial conservative treatment of the elbow.

Petitioner was next seen by Dr. Van Fleet for his neck and low back. While Petitioner testified that Dr. Sams referred him to Dr. Van Fleet, neither Dr. Sams' records nor Dr. Van Fleet's records corroborate that. Dr. Van Fleet's records and Dr. Gornet's records (PX 9, 3/8/16 o/v) suggest that the workers' compensation carrier sent Petitioner to Dr. Van Fleet. Respondent is, therefore, responsible for the charges of Dr. Van Fleet.

During the course of Petitioner's treatment by Dr. Sams and Dr. Van Fleet, he presented to his family physician, Dr. Shroff, for a regular check-up and head cold. Dr. Shroff noted that Petitioner had been in a work accident; however, Dr. Shroff directed Petitioner to see his own doctor "under Workers' Compensation" for his work injury. Dr. Shroff's notes don't indicate any specific treatment or testing being rendered for Petitioner's work injury. His pre-accident diagnosis of degenerative back disease was noted. The Arbitrator finds that Petitioner did not present to Dr. Shroff on the 9th seeking treatment for his work injury and no charges associated with treatment by Dr. Shroff on that date are awarded herein. Accordingly, Respondent is not responsible for any bill for services on November 9, 2015.

Petitioner sought out treatment by Dr. Nathan Mall, a specialist in upper extremity injuries. This was his second choice of physician. Dr. Mall also noted continued neck and low back problems and referred Petitioner to Dr. Matthew Gornet. The evaluations and treatment by Dr. Mall and Dr. Gornet were reasonable and necessary for the injuries sustained by Petitioner on October 26, 2015. Their bills are awarded.

Accordingly, Respondent shall pay to the providers the sums outlined herein pursuant to the medical fee schedule.

Issue K. Prospective Medical Care.

Petitioner is awarded prospective medical care for his left elbow as recommended by Dr. Mall.

Petitioner's testimony of continuing left elbow symptoms is supported by his testimony and the medical evidence of record. There is no reference within his treating physician's records to any complaints of left elbow problems prior to the work accident. His testimony that he was able to perform his full work duties without issue prior to his fall is also uncontradicted. He attempted to resume his normal activities, but has been unable to do so because of continuing left elbow symptoms.

The medical records of Kirby Medical Center and Decatur Memorial Hospital document complaints of left elbow injury. Dr. Sams, Dr. Mirkin and Dr. Mall also detail a consistent history of continuing left elbow symptoms.

The opinion of Dr. Mirkin is given less weight than that of Dr. Mall. Dr. Mirkin saw Petitioner on one occasion and did not review the left elbow MRI or the later diagnostic nerve conduction studies. Dr. Mirkin acknowledges that he only occasionally sees patients with elbow conditions, whereas Dr. Mall testified he regularly sees and treats patients with elbow conditions as part of his usual medical practice. In this case, Dr. Mall's opinion is more fully informed by a more complete physical exam and work-up, consisting of multiple physical exams performed over time, MRI findings consistent with injury, and nerve conduction studies diagnostic of his condition. The preponderance of evidence weighs in favor of Dr. Mall's opinion that conservative treatment has been exhausted such that surgical intervention is reasonable and necessary.

Petitioner is denied any prospective medical care for his lumbar or cervical spine. In support thereof, the Arbitrator relies upon her causation determination set forth above. Petitioner has been working full duty since April 11, 2016. He did not testify to any ongoing low back or neck complaints nor did he seek any further treatment beyond the elbow surgery which has been recommended by Dr. Mall.

Issue L. Temporary Total Disability (TTD) Benefits.

Petitioner is awarded TTD benefits from October 27, 2015 through January 6, 2016, January 27, 2016 through April 11, 2016, and July 28, 2016 through September 11, 2016. While the record doesn't contain any off work slips/light duty restrictions until November 18, 2015, the parties stipulated to the period beginning October 27, 2015 through December 28, 2015. (AX 2) Dr. Van Fleet, as of November 18, 2015, took Petitioner off work for six weeks and when Petitioner failed to appear for his next examination on January 6, 2016 he released him to full duty work. Thus, by January 6, 2016 both Dr. Van Fleet and Dr. Mirkin felt Petitioner could work full duty. None of Petitioner's treating doctors had Petitioner off work during the aforementioned time.

Dr. Mall then imposed restrictions as of January 27, 2016 for Petitioner's left elbow and it appears those restrictions could not be accommodated. Dr. Mall released Petitioner to full duty work on January 27, 2016. He again imposed restrictions from July 28, 2016 through September 11, 2016. While apparently Petitioner was no longer employed by Respondent (as he had gone to work for ADM in April of 2016) Petitioner was not yet at maximum medical improvement. Petitioner did not claim TTD benefits when he secured employment with new employers. In so finding, the undersigned relies on the opinion of Dr. Mall over that of Dr. Mirkin to conclude Petitioner is not at maximum medical improvement for his left elbow as a result of his work injury.

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STATE OF ILLINOIS)
) SS.
COUNTY OF WILL)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Antoinette L. Walker,

Petitioner,

vs. NO: 13 WC 07692

Schneider Logistics,

Respondent.

17IWCC0499

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, temporary total disability (TTD), medical expenses, and permanent partial disability (PPD) 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 was a 41 year old employee of Respondent, who described her job in the receiving department as a 'hauler'. Petitioner is currently an 'on-call' cashier at Family Dollar working 4-12 hours per week. Petitioner has been doing the cashier job since November 2014. Since April 2016, she has also worked part time overnight at Cornerstone Services. Prior to Family Dollar, Petitioner started working for Respondent in June 2010. When Petitioner first started with Respondent she was in receiving as a hauler, taking freight from the trucks to the specific location; she did that the majority of her time at Respondent. During peak season she would pick orders or help pick orders. As a hauler she was required to operate machinery to move the material around. Her choice of equipment was always the PR forklift. She had been trained when she initially

started there on the PE electric pallet jack, and the PR, and RR standup forklifts. Petitioner testified to having work experience on fork lifts and that the RR steered differently from what she was trained on. She stated that she was not comfortable with the RR steering so she stuck with PE and PR. For working in receiving, she preferred the PR over the PE as it carried more freight and she felt more effective with productivity. Petitioner testified that she was terminated in November 2014.

- Petitioner testified that in early 2013 she was ordinarily using the PR. Early 2013 she had an illness that kept her away from working; she had a bad flu and blood pressure issues. When she returned to work after that illness she was told to only use the PE. The PR's were on the shipping side roped off to not use. In the days before February 13, 2013 she would get any PE unit available as it was close to peak season. Petitioner identified PX 5 as a photo of PE 216, one of the units she had used. Petitioner viewed PX 6 and identified it as a photo of the same unit; with the forks showing. The right side of the photo was indicated as the rear of the unit, right side. When she drove it the material was on the back of the unit. Petitioner testified that she stood on the left side of the platform on the unit because she is right hand dominant and she indicated her strength was mostly on her right. Petitioner indicated there is a throttle to push to go forward and pull back which begins to slow it to stop and go to reverse. Petitioner indicated the steering handle on it; towards top of photo in PX 5. She indicated the photo did not show how the handle looked when driving the unit. It had to be pulled down as the safety was on and the photo was it in the resting position, fully up. She agreed there was no steering wheel as such on it. She indicated the handle was pulled down and then you steered turning your feet on the platform, and you turn around as well. She noted most of the time with the load on the back it is heavy; at least 4 pallets. On the date of accident, February 13, 2013, Petitioner testified the unit was difficult to steer and when she went to the left she had to use more body weight and more her knees into the truck, leaning to keep her balance and stability as she turned the truck. Her knee came in contact with the unit metal part. Petitioner indicated that on a 12 hour shift she did that with her knee 30-50 times to turn to the left. Operating the unit she also had to get on and off the unit from time to time. She had to step down to scan the freight and get back on and take the freight to the area. Petitioner testified to doing this repetitively. Petitioner testified that on that day, and the prior days using that unit, her knee began to ache from the up and down and repetitions of hitting it on the equipment. When she came in that morning she was only able to last a few hours before it swelled up and she was in a lot of pain. She had also worked February 14, 2013 and some point that day she reported what she was feeling to her supervisor, Devante Rogers, and then she went to the dock and talked to Ron Ellerson. Petitioner stated Mr. Ellerson immediately got Petitioner off the equipment and took Petitioner to Christine (medical person on site). Petitioner indicated she made a report then with Mr. Ellerson. She waited for Christine to come over to the break room area to get a better look at her leg. Petitioner testified that later that day she went to the doctor, Dr. Darshma Patel. Petitioner stated the doctor took x-rays, took her off work the rest of the week, placed her on light duty, and she sent her home. Petitioner returned to the doctor the next week and was given crutches and advised to keep her leg up. When she went to Respondent with the restriction note they assigned her to check equipment badges and making sure the equipment was signed off; she did not work using the pallet jacks. She was instructed to

work receiving to check the badges. Petitioner indicated that she had to hop around on the crutches to the other end of the facility. With hopping through the facility she started getting dizzy and her blood pressure was going up and the supervisor saw her swaying on the crutches and put her in a golf cart and took her to the receiving desk and an EMT was called as her blood pressure was severely high; she believed she went to St. Joseph Hospital and she believed they did x-rays and MRI of her knee; a head CT and also a stress test. After she was released from the hospital she followed up with Dr. Sampat, an orthopedic specialist, whom she saw on February 21, 2013 at the hospital. Petitioner indicated that she was released from the hospital February 22, 2013.

- Petitioner returned to see Dr. Sampat and he ordered therapy. Petitioner testified that she treated with him through June 10 and July 1, 2013 with therapy. Petitioner testified in therapy her left knee was not getting any better. She had been on crutches February 23, 2013 through about mid-March and she was placed in a brace March/April. The doctor took her off the brace and later placed her back with it; while she was still in therapy. Petitioner saw the doctor September 6, 2013 and the doctor eventually released her to light duty, 5-6 hours per day. She saw the doctor again September 27, 2013 after trying work and the doctor released her then to try full duty. Petitioner stated that she returned to Respondent. Petitioner also stated that she believed she had also seen her PCP (Dr. Patel) after that release. Dr. Patel referred Petitioner to Dr. Koumandari, (done November 15, 2013). On October 18, 2013, Dr. Sampat ordered another MRI of her left knee which was done October 28, 2013. Dr. Sampat referred Petitioner for another exam with Dr. Fuentes about November 11, 2013. Upon referral to Dr. Koumandari Petitioner stated that she underwent an injection to the knee on November 15, 2013. Petitioner was still in therapy December 3, 2013 at St. Joseph. Petitioner indicated the therapy offered her no relief. Petitioner saw Dr. Koumandari January 10, 2014 and a repeat MRI was done February 17, 2014. Petitioner returned to the doctor February 21, 2014. Petitioner was still in therapy then. Petitioner indicated that her knee continued to swell with therapy and she felt worse. Petitioner stated that she would have to leave at times and it would sometimes hurt more after than it did before therapy. Petitioner stated that she was off work then. Dr. Sampat released her to full duty work September 27, 2013 and she was later taken off work again by Dr. Koumandari, about November 2014 or early December 2014. Petitioner stated that she was in therapy through February 27, 2014 and she saw Koumandari again after that; about February 27, 2014.

- Petitioner saw Dr. Coe for Petitioner's IME on November 23, 2015 and Dr. Neal for an IME for Respondent on May 14, 2014. Petitioner had also seen Dr. Metcalf, a chiropractor, on and off. Petitioner indicated that when she returned to work at Family Dollar as a cashier she let them know of her restrictions. She is allowed to sit/stand as needed. At Cornerstone Services she takes care of the mentally ill and disabled and they accommodate her; she prepares meals and drives them to school and day programs. She has to be on her feet from time to time with that work. She stated while there she is in constant pain sitting or standing. She does drive in personal life to go to the store. She stated at home her daughter helps around the house. Petitioner does cook and clean and wash dishes. She tries not bending or mopping. If she gets down to the floor she has difficulty getting up with her knee pain. Shopping she uses the cart to lean on; sometimes

she uses the motor cart.

- Mr. Erwin is the Human Resource (HR) business partner for Respondent and had been for 4 years; as long as he has been with Respondent. He was previously with ComEd for 27 years and Lyondell Basell for 4 years. His position at Respondent entails HR policies, associate positions, payroll/benefits of the associates, and he manages all the staffing agency support from external providers. Mr. Erwin has access to employee attendance records. He stated there is an E-time system the associates use with their barges to swipe the clock in and out and that goes to ADP and payroll system for reporting. The system had been there when he started in October 2012. Mr. Erwin identified RX 1 as punch detail from the system noting badge numbers and times in and out or when put in manually by a supervisor or HR person. He indicated the document was for Petitioner. Mr. Erwin indicated he knew Petitioner from working there. Mr. Erwin indicated that from January 1, 2013 to February 14, 2013 Ms. Walker (Petitioner) worked for Respondent 11 days (January 15, 16, 17, 21, 22, 29, 30, 31, & February 12, 13, & 14). He believed Respondent offered furlough the last 2 weeks in December and for the month of January (slow period). He stated he believed it was offered to all associates and they had enough volunteers for the company's needs. The report does not indicate furlough awarded to Petitioner. Mr. Erwin indicated that it showed intermittent FMLA in January which would be inconsistent with furlough (it was a 6 week period; it has to be continuous). Mr. Erwin agreed that with respect to the punch system, sometimes the cards get damaged and do not work in the reader. He stated it was like a credit card with a bar code that you swipe through the machine. He indicated the employee would know if it malfunctioned. He stated there had been times when the system was down and associates would swipe their cards even if the clock was not operating as it was still recording in the system. He indicated that occurred 3-4 times in 4 years. As to the equipment Petitioner was operating the week of February 12, 2013, he stated that OSHA requires pre-inspection prior to operating. He indicated there is a process for the associates to go through and check the operating pieces and there is a form they initial for safety conditions. Then they can use the equipment for the day. He indicated if the machine is not in operating condition the associates reports it and they have a site maintenance team to take care of the malfunction. He did not know if they had any contacts for repairs then. He could not guess how often forks are repaired. Mr. Erwin stated that when an injury is reported the supervisor fills out an incident form that is attached to and e-mailed to the incident reporting team which he is a part of. Mr. Erwin stated that he is how he is notified of any incidents. Mr. Erwin identified RX 3 as an injury investigation form by Mr. Ellerson regarding Petitioner; he did not recall reviewing it in advance of the hearing. The form was complete. He was not aware of Petitioner contacting Respondent as to accommodations to return to work after she was off; that would be part of his responsibility. Mr. Erwin indicated that he was not aware of anyone besides Petitioner reporting a repetitive knee trauma type injury operating the PE forklift. He indicated a reason for the incident report is to identify the root cause of an incident to make sure it does not occur again. He again indicated he had no other such reports of similar incident.

- Mr. Cotton testified as to being a supervisor at Respondent for 2 years. He was a trainer before that for 3 years. As a trainer he trained everyone on equipment and for re-

certification on equipment. He had been trained by, for several months, another trainer for that. He worked together with Crown Supplies; maker of the equipment. He was initially trained on the equipment in 2010. He did that for a year before he became a trainer. He had to first find out from the supervisor what machine was to be trained on and he would show the rules and safe operation of it and finally certify the person on the equipment. It was the same process for everyone. He agreed Petitioner would have gone through the process so she could be a hauler. Mr. Cotton viewed RX 5 & 6 and he identified those as photos of the PE machine lift made by Crown. He indicated those were used in February 2013.They can go 6-7 miles per hour. He noted the people are instructed to sign the 119 sheet (OSHA form) that it is operating properly. He indicated there are about 20 things to check on it; i.e. braking. Mr. Cotton testified that he had never seen any employee twisting their knees repeatedly operating the forklift. Mr. Cotton testified that if driving properly there is no straining physically to make it turn. He indicated there was no jolt to operate or stop it. They are trained to stop by plugging. Mr. Cotton stated that if the machine is stopped in that manner then there is no jolting. He indicated if someone finds a problem with a forklift they take it to Crown on site and Crown would say whether it was safe or not. He indicated sometimes the employee is provided a different forklift. He indicated some days there are other lifts available and sometimes not. Mr. Cotton stated that the surface there is smooth concrete; no cracks; just seams wherever the pieces of concrete come together. He indicated to his knowledge there was no impact experienced to any body part. Mr. Cotton indicated he had ridden the forklifts and he never experienced any impact to any body part. He indicated that you are in balance when placing the feet spread apart in a certain way. He indicated if your feet are both on the same side it makes it un-level and unbalanced. They can be on either side of the machine; whatever is more comfortable for them. He indicated separating the legs provides balance while operating the machine. He indicated one hand is on the handle bar and one on the throttle at all times. Mr. Cotton indicated the operator faces forward away from the forks. He testified they train everyone to turn steering with the body and not just the arms; it is hard to turn with just the arms. He indicated the whole platform on it is for walking on. Mr. Cotton testified that to his knowledge there were no other employees reporting repeated banging the knees on the PE's.

The Commission notes that there is variation as to mechanism of injury reported by Petitioner. The initial history indicated twisting and turning and getting on and off multiple times through the day. She did not initially indicate striking her knee to help turning but that would be consistent with the bone bruising and edema noted in the records and MRI. Petitioner indicated striking her knee 30-50 times per shift which may be consistent with those findings. The treating doctors noted a work knee injury but other than via a mechanism, there are no causal opinions there. Dr. Sampat (February 25, 2013) did note she had injured her knee 'striking her knee' on the machine; again consistent with those early findings. Petitioner's IME opined a causal connection while Respondent's examiner questioned a mechanism of accident and indicated no causal connection, but there may have been some temporary aggravation of an undetermined knee condition and he found complaints out of proportion to objective findings. Petitioner may not have articulated well to the treating doctors, but there is a mechanism of the turning and twisting and getting on and off and striking her knee multiple times throughout the day supported

in the treating records to find Petitioner met the burden of proving accident that arose out of and in the course of her employment. Likewise there is evidence supporting some causal relationship to a left knee injury with the MRI showing the edema and bone bruising to find Petitioner met the burden of proving a causal relationship to some extent. The later MRI indicating a tear in 2014 clearly would not extend the causal connection back to the accident when there was no indication of that on the initial MRI. 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 of accident, and, herein, affirms and adopts the Arbitrator's finding as to some causal connection.

The Commission, with the above finding of accident and causal connection, finds the evidence and testimony supports the finding that Petitioner met the burden of proving entitlement to the award of temporary total disability benefits. The Commission notes that Respondent addressed the issue only within context of causal connection and did not argue the lost time period. 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 total temporary disability.

The Commission, with the above finding of accident and causal connection, finds the evidence and testimony supports the finding that Petitioner met the burden of proving entitlement to the award of medical expenses. The Commission notes that Respondent addressed the issue only within the context of causal connection and Respondent did not argue as to the reasonableness and necessity of medical treatment or prospective medical care. 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 medical expenses.

The Commission, with the above finding of accident and causal connection, finds the evidence and testimony supports the finding that Petitioner met the burden of proving entitlement to a permanent partial disability (PPD) award. The Commission, however, finds the award somewhat excessive and inconsistent with prior decisions of a similar nature and resulting ill-being. The Commission, considering the weight of the evidence, herein, reduces the PPD award to find that Petitioner suffered a permanent partial disability of 3% loss of use of her left leg (6.45 total weeks at $391.65 per week--$2,5236.14 total PPD).

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $435.17 per week for a period of 31-1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $391.65 per week for a period of 6.45 weeks, as provided in §8(e)(12) of the Act, for the reason that the injuries sustained caused the 3% loss of use of her left leg.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $8,448.73 for medical expenses under §8(a) of the Act.

17IWCC0499

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

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $25,700.00. 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 16 2017
d-6/29/17
DLG/jsf
045

David S. Gore

Stephen Mathis

Kevin Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

WALKER, ANTOINETTE
Employee/Petitioner

Case# **13WC007692**

SCHNEIDER LOGISTICS
Employer/Respondent

17IWCC0499

On 11/28/2016, 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 0.60% 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:

2687 KROCKEY CERNUGEL COWGILL ET AL
THOMAS E COWGILL
3180 THEODORE ST SUITE 102
JOLIET, IL 60435

0075 POWER & CRONIN LTD
RORY McCANN
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF WILL)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
CORRECTED ARBITRATION DECISION

ANTOINETTE WALKER,
Employee/Petitioner

v.

SCHNEIDER LOGISTICS,
Employer/Respondent

Case # 13 WC 07692

Consolidated cases: _____

17IWCC0499

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Robert Falcioni**, Arbitrator of the Commission, in the city of **New Lenox**, on **October 11, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 13, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$33,943.00**; the average weekly wage was **$652.75**.

On the date of accident, Petitioner was **41** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **$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

With respect to reasonable and necessary medical services, Petitioner is awarded the sum of $8,484.73 subject to the applicable fee schedule, in accordance with the Addendum to this Order attached hereto.

Petitioner is awarded TTD from February 15, 2016 through September 6, 2016 a total of 31-1/7 weeks in accordance with the Addendum attached hereto.

With respect to permanent partial disability, the Petitioner is awarded 10.75 weeks permanent partial disability, because she has sustained a 5% loss of use of her left leg under Section 8(e)(12) of the Act.

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

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

Robert E Abrams

Signature of Arbitrator

November 22, 2016

Date

NOV 28 2016

BEFORE THE ILLINOIS
WORKER'S COMPENSATION COMMISSION

ANTOINETTE WALKER,	)	
	)	
Petitioner,	)	
	)	
v.	)	Case Number 13 WC 07692
	)	
SCHNEIDER LOGISTICS,	)	
	)	
Respondent.	)	17IWCC0499

ADDENDUM TO ARBITRATOR'S DECISION

FINDINGS OF FACTS

Petitioner testified as follows. Petitioner, Antoinette Walker, hired on to Schneider Logistics in June of 2010. She worked in the Receiving Department as a "hauler" which required her for most of the work day to operate electrically powered forklifts. The forklifts utilized by Schneider came in two varieties, one unit designated "PR" and another designated "PE". Walker testified that she preferred the PR unit and never had any trouble operating it. But for the first two weeks in January, Walker was placed on furlough, or what she referred to as "peace time" between January 1, 2013 and January 14, 2013. When she returned to work, she was assigned to "a PE" unit, designated as "PE-216" (P. Ex. 5 and 6). That machine provides a platform for the operator to stand on at the front of the unit that wraps all the way around its nose, while its forks are actually located at the unit's rear. According to Walker's testimony, the unit is controlled by a steering column which when operated must be pulled down to reveal a set of handlebars. She stated that in order to slide the unit's forks under a pallet, she must pivot around and look over her shoulder so she can see to engage the pallet. She testified that PE-216 is designed to operate on a very short turning radius and the platform is designed to allow the driver to walk all the way across the front of the vehicle on the platform provided to facilitate the directional control of the vehicle.

Walker testified, however, that PE-216's steering resistance was stiff and it required her, while forcibly turning the handlebars, to press her left knee against the nose of the unit, approximately at the area where the "PE" designation is stenciled on the unit.

Walker stated that she worked 12 hour shifts Mondays through Thursdays when she returned after the "peace time" furlough. She further testified that because of the difficulty steering the unit and the requirement to pivot so she could see the forks at the back, she repeatedly had to forcibly press her knee against the nose of the forklift 30 to 50 times a day. She testified that on February 13, 2013 as she was operating the forklift, the constant striking of

her knee against the unit started to cause her pain in the knee. In court, she demonstrated the technique necessary to steer the forklift, and the Arbitrator notes that she did so credibly. She testified that February 13, 2016, at the end of her shift, she informed her supervisor that the knee was hurting from use of the unit, but only did so in passing. She complained to the company nurse and she was sent home the next day. She stated that her knee was so swollen at that time that she could not pull her pants leg up for the nurse to examine it. She testified that she saw her primary care physician, Dr. Patel, who furnished her with a pair of crutches. She was assigned light duty where she was allowed to sit down and keep her leg up. However, a week later she was assigned by her supervisor to do an equipment check which required her to ambulate to the receiving end of the warehouse. On the way, while using her crutches, she felt faint and dizzy. She was taken to the Saint Joseph Medical Center Emergency Room on February 20, 2013 (P. Ex. 1), where she was given a DT angiogram and a brain MRI to rule out ischemia. She complained at the Emergency Room of a pain in the left knee and was prescribed an MRI there by Dr. Sampat (P. Ex. 1)

Petitioner produced at trial Michael Whitfield, who was employed by Schneider as a picker in 2010 and operated the "PE" unit until he left Schneider's employ in 2011. He testified that he was familiar with and did operate the machine, but he could not say whether he operated Walker's unit. He indicated it was necessary to press the knees against the machine while trying to turn the unit and that he had to exert pressure with his knee against the machine in order to steer it. He never reported any knee injury of his own to Schneider and he never told the safety director he had any problem with the PE units, although the testified that he quit working for Respondent due to knee pain caused by operating the PE unit.

Rick Erwin testified on behalf of Respondent. At the time of trial, Mr. Erwin was the Human Resources Director at Schneider and had been so employed since 2012. He testified that he had access to the employee attendance records in his function as HR Director. The employees were issued a badge which could be swiped to indicate the time they clocked in and clocked out. He indicated that a furlough was offered for the last two weeks of December and the month of January however, Petitioner, according to the electronic time records, worked January 15, January 16 and January 17, January 29, January 30, January 31, February 12, February 13 and February 14. She did not work on any other occasions in January or February up to February 12 because she was on FMLA leave, not furlough. He did indicate that sometimes the employee's cards malfunction, but a light at the register signals a malfunction when it occurs. There were a few occasions when the entire system was down when a swipe is not recorded, but that that had happened only 3 to 4 times. He indicated that he had not heard of anyone else complaining of the lifts or any knee problems as a result of their operation.

Brian Cotton also testified on behalf of Respondent. Mr. Cotton testified that for the past 2 years he has been a supervisor at Schneider. Before that he was a trainer for three years. His job was to train the new employees on the equipment, including the forklifts. Each employee takes a test on the pieces of equipment and then each is certified for operation of that unit.

With respect to the operation of the "PE" unit, he testified that it is best done if the driver's legs are spread apart on the right or left side of the steering mechanism, whichever side is more comfortable. The steering is accomplished with the body, not just with the arms. He testified that if the operator moves his or her feet, it is easier to steer. He had never experienced any other employee having a problem with contacting any body part with the machine while it was being operated. He never saw an employee straining a knee and that would not happen if the employee were driving properly. Unit PE-216 was never taken out of service for any defects. If any employee detects something wrong with the machine, there is a "Form 119" an inspection sheet, which can be used to describe exactly what is wrong with the machine. The Arbitrator notes that Mr. Cotton is a male approximately 6'2" tall and that Petitioner is a female whose medical records indicate is 5'6" tall.

After Petitioner's initial consultation with her primary care physician, while she was at the Presence Saint Joseph Medical Center Emergency Room she was treated by Dr. Sampat, an orthopaedic surgeon, on February 20, 2013 (P. Ex. 3, 2/20/13 Report). He examined her and the MRI of the knee that was performed during her hospital stay. It appears that from Dr. Sampat's hospital note that he was requested to do a consult on the knee by her primary care physician, Dr. Patel. None of the medical notes in Petitioner Exhibit 2 indicate a February 14, 2013 visit with Dr. Patel, but there does not appear to be any other reason why Dr. Sampat would thank Dr. Patel for the orthopaedic referral.

Dr. Sampat saw Petitioner after she was released from the hospital at his office on February 25, 2013 (P. Ex. 3). He interpreted the MRI scan as showing some "edema within the proximal tibia, consistent with a possible bone bruise or non-displaced angular fracture" (P. Ex. 3, 2/25/13). No actual fracture was identified at that time. He referred her for physical therapy and kept her off work.

Petitioner did in fact start physical therapy at the Parkview Physical Therapy Center on May 8, 2013 (P. Ex. 3). Dr. Sampat saw her again on May 15, 2013, and he diagnosed a bone bruise "versus non displaced angular fracture of the tibial spine" (P. Ex. 3). He kept her off work. He also observed that she might need "an updated MRI of the knee to see if there has been any internal change in her fracture healing" (P. Ex. 3, 5/15/13 note). On June 10, 2013 he saw her again and Dr. Sampat noted residual left knee pain and swelling, but with improved range of motion (P. Ex. 3). He recommended additional physical therapy which was carried out at Parkview Orthopaedic through July 1, 2013. She was kept off work until further notice. On July 8, 2013 Dr. Sampat noted a 70% improvement per Petitioner's report. Range of motion had improved to 110° of flexion and Dr. Sampat recommended that she transfer to work conditioning (P. Ex. 3). He kept her off work. When Petitioner returned to see Dr. Sampat on September 6, 2013 it was noted that she had not started work conditioning due to insurance issues. The office note (P. Ex. 3) reports that she had not been approved for work conditioning by the Workers' Compensation carrier. She requested to try going back to work on a light duty basis and Dr. Sampat gave her a limited duty slip specifying 5 hours a day, 5 days a week. Of note, at the September 6, 2013 office visit Dr. Sampat reported that Petitioner had "a bone

bruise and inflammation of the tibial spine on MRI scan of the knee". The next time that she saw Dr. Sampat on September 27, 2013, she told him that work would not accept the light duty and that she would like to try full duty work, 5 hours a day, 4 days a week. He wrote her a limitation slip for that restriction (P. Ex. 3, 9/27/13). On October 18, 2013, she did report to him that she had gone back to work but she was now complaining of pain "because she has to get in and out of the truck and has vibration about her knee" (P. Ex. 3). Dr. Sampat at that visit noted that "she has not had any frank symptoms of instability". He referred her to see Dr. Fuentes, a sports medicine surgeon at Parkview, but he maintained her work schedule at 5 hours a day, 4 days a week with regular job duties. He also ordered a new MRI of the knee to determine if there was any change.

The new MRI scan was performed on October 28, 2013, and the scan showed the original tibial edema had resolved without any other abnormalities. When she returned to Dr. Sampat on November 1, 2013, she still complained of pain but his office note states "from a knee perspective, it is unclear to me why the patient still has pain" (P. Ex. 13). He found her to be at MMI as far as her knee was concerned and returned her to work full duty with the caveat that she was to see Dr. Fuentes, a sports medicine orthopedist, before doing so. Dr. Fuentes saw Petitioner on November 11, 2013, prescribed ibuprofen for pain during the work day, specified that she could continue working full duty, found her to be at MMI and discharged her from care (P. Ex. 3, 11/11/13).

That same day, Petitioner then went to Dr. Patel for a second opinion. Dr. Patel did write a referral, apparently to another orthopaedic surgeon, Dr. Komanduri. Dr. Komanduri's physician's assistant saw Petitioner on November 15, 2013. Parenthetically, Petitioner followed up with Dr. Patel for her knee pain on February 27, 2013, March 8, 2013 and March 22, 2013. All of these follow up visits were done concurrently with Dr. Sampat's care and all of the visits ended with a doctor's note with the doctor's note simply indicating pain in the left knee. It appears, as far as can be ascertained from the medical records, that Petitioner never actually saw Dr. Komanduri during these visits, but treated with his nurse practitioner or physician's assistant. No other specific care was reported during those office visits.

Dr. Komanduri's physician's assistant indicated that the physical examination may disclose a "meniscal abnormality" and he gave her a corticosteriod injection and prescribed additional physical therapy. She was returned to limited duty, four hours per day, four days per week with no pushing, pulling, climbing or kneeling (P. Ex. 4, 11/15/13). Petitioner did in fact resume physical therapy on December 3, 2013 at Dr. Komanduri's facility. On December 13, 2013 Petitioner did report some improvement, about 30% to 40%, but the pain remained. In the meantime, she had been terminated from her job at Schneider. She kept on doing physical therapy at Dr. Komanduri's facility with little improvement, and on January 10, 2014 Dr. Komanduri prescribed a repeat left knee MRI scan. The repeat MRI scan (2/17/2014) disclosed a small full thickness cartilage "defect" at the medial aspect of the lateral tibial plateau consistent with condromalacia, but no meniscal tears were detected (P. Ex. 4). She maintained her physical therapy through February 27, 2014 (P. Ex. 4) and has had no care since.

Petitioner underwent a Petitioner's Section 12 examination by Dr. Coe on November 23, 2015 (P. Ex. 8). Dr. Coe noted a slightly antalgic gait and normal range of motion with the exception of a 20° reduction in flexion for the left knee. He measured a 1-1/2 inch reduction in circumference of Petitioner's thigh, 18 inches above the left knee and a 3/4 inch reduction in circumference of the calf just below the left knee. There was a very mild reduction of resistant flexion on the left knee. Dr. Coe opined that Petitioner had suffered "condromalacia and bone bruising causing both acute and chronic multi factorial left knee pain" (p. 7). He also opined that the work she did at Schneider on February 13, 2013 provided a causal relationship to the current condition of ill being she suffered. He specified that she should have a work restriction including prolonged standing or walking, avoidance of dealing with squatting, and a light physical demand level limitation (p. 8).

Respondent sent Petitioner to a Section 12 examination with Dr. Neal on May 14, 2014 (R. Ex. 5). He examined her and her medical records extending back to September 15, 2010. His Report identifies 20 medical visits between September 15, 2010 and February 14, 2013 (the date of accident). In all but one of those encounters with a medical practitioner, Dr. Neal indicated that there was no notation of any left knee pain. He did note in his interview with Petitioner that she denied ever having any kind of left knee pain before February 13, 2013 (R. Ex. 5, ps. 8-10). Dr. Neal agreed with the initial MRI Report of February 21, 2013 (P. Ex. 1; P. Ex. 3) that there was "bone marrow edema at the base of the tibial spine" (Report, p. 21). He agreed with the second MRI Report of October 28, 2013 that "the bone marrow signal abnormality in the tibial spine has resolved and in these images there is no significant bone marrow edema" (Report, p. 21). However, the third MRI Report of February 17, 2014 ordered by Dr. Komanduri (P. Ex. 4) described a 1 millimeter deep cartilage fissure involving the medial aspect of the lateral tibial plateau with mild subchondral edema without any meniscus tear. After reviewing the MRI film itself, Dr. Neal did not agree with those MRI findings.

Dr. Neal opined that there was no causal connection between whatever encounter Petitioner had with the forklift on February 13, 2013 or February 14, 2013, and her current knee condition. He found at most "knee discomfort which would have been a temporary aggravation of a yet to determined intrinsic knee condition which most likely is confounded by underlying psychogenic currents" (Report, p. 23). With respect to the reasonableness and necessity of care, he opined that "an initial evaluation to rule out an acute event or occupational injury might be reasonable. The initial medical evaluation, February x-rays, and February 23 MRI might have been treatment and evaluation deemed reasonable to evaluate what she had in the process of determining both what she had and whether there was an occupational relationship. He then stated that "I cannot state that I would have held this opinion (i.e., no causal relationship) in the first week or two after any February 13, 2013 complaints until the necessary evaluation and clinical information was obtained..." (Report, p. 24).

Dr. Neal found Petitioner to be at maximum medical improvement, but opined that "any employment restrictions, limitations or issues are related to her intrinsic knee condition and

probably affected to some degree by underlying biopsychosocial issues and are not related, caused or made necessary by occupational activities in February 2013" (p. 24).

III. CONCLUSIONS OF LAW

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

Petitioner's uncontroverted testimony is that in order to steer the pallet jack (forklift), the steering was so difficult that she had to use her body and to press her left knee against the nose of the machine in order to complete a turn. The need to do a maneuver in such a manner was substantiated by witness, Michael Whitfield, who, although he left the Schneider employ in 2010 or 2011, testified that he had used the same machine as identified by Petitioner and had experienced similar problems with his knees.. There is no testimony contradicting Petitioner that this was in fact the procedure she used in order to steer the machine. However, Brian Cotton, Respondent's trainer and later supervisor, testified that it was not necessary to use the pressure of a knee in order to assist in the steering, and it was best procedure to steer with the driver's knees spread apart. His testimony is that the driver should stand on either the left or the right side of the steering tower, whichever is more comfortable. He did testify, however that it was necessary to use one's bodyweight to assist in steering the machine and that while doing so it would often be necessary to shift one's feet. Petitioner testified that she would stand on the left side of the steering tower while operating the forklift and that using her bodyweight to help steer caused her left knee to come into contact with the metal body of the lift between 30-50 times per day.

The Arbitrator notes that histories in the medical records indicate different mechanisms of injury as recorded by various medical providers, that the most consistent history given is that Petitioner experienced pain while either getting on and off the forklift numerous times during her work day, or suffered a twisting injury of some type while at work. It must also be noted however, that as early as February 25, 2013, a physical therapy note from Dr. Sampat's office stated that Petitioner had injured her left knee "striking a machine".

It is also noted that the result of the first MRI taken of Petitioner's left knee following the alleged accident showed edema and bone bruising consistent with the type of injury she alleged occurred.

Based on the record as a whole, the Arbitrator finds that the record supports Petitioner's testimony that she did in fact use her body and her left knee in helping steer the forklift, and that her left knee did come in contact with the metal housing of the lift on numerous occasions on both February 12 and 13, 2013, as she alleges. Consequently, the Arbitrator finds that she did sustain an accident that arose out of and in the course of her employment.

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

In determining whether medical causation has been established, it is noteworthy that Respondent's Section 12 doctor, Dr. Neal, went through Petitioner's medical records for two years prior to the date of accident. Out of the 20 visits to physicians that Ms. Petitioner engaged in, none of them showed any complaint by her of left knee pain, or any other problem with her left knee. There is no indication, therefore, that Petitioner had a pre-existing condition in her left knee.

Further, it is noted that Petitioner made a prompt complaint of her symptoms the date of and the day after the accident. The employer's nurse sent her home on February 14, 2013, a fact which was corroborated in Dr. Neal's Report. Although her testimony that she went the next day to Dr. Patel, her primary care physician, is not corroborated by an office note, it is noted that Dr. Patel referred to her to Dr. Sampat which is borne out by the notes of Dr. Sampat at Presence Saint Joseph Medical Center on February 22, 2016 (P. Ex. 1; P. Ex. 3). Consequently, Arbitrator concludes that Petitioner registered a prompt complaint after the incident of a condition of ill being for which there was no indication of complaints in her prior medical care.

The question then arises as to what specific condition of ill being did Petitioner suffer as a result of the accident. An MRI taken at the hospital a week after the accident disclosed an edema and bone bruise to the tibial spine, and that is what Dr. Sampat registered in his office note of May 25, 2013 as her condition of ill being. Given that there was no evidence of any pre-existing condition in the left knee, given a prompt complaint of pain in the knee and an MRI that showed this condition a week later, and given the treatment afforded by Dr. Sampat addressed to the condition, the Arbitrator finds that the accident did in fact cause a bone bruise to Petitioner's left tibial plateau and that initial condition of ill being was related to the accident.

The next question is what is Petitioner's current condition of ill being and whether it is causally related to the initial injury. After physical therapy under Dr. Sampat was completed, Petitioner still complained of left knee pain although there had been some improvement. When Dr. Sampat sent her for her second MRI, the results of that MRI indicated that the initial bone bruise and edema had healed and that the MRI was read as objectively normal. He found her to be at MMI at that time and returned her to work full duty conditioned, however, on the agreement of Dr. Fuentes, a sports medicine orthopedist colleague. She saw Dr. Fuentes in his office, who on November 11, 2013 found that she was at maximum medical improvement and released her from care and again returned her to full duty work. Petitioner, however, went that same day to Dr. Patel, and asked for a second opinion. He referred her to Dr. Komanduri, where she was seen by a physician's assistant who ordered a third MRI which was performed on February 17, 2014, almost exactly 1 year after the first MRI (P. Ex. 4). That MRI disclosed full thickness cartilage defect at the medial aspect of the lateral tibial plateau consistent with chondromalacia (P. Ex. 4). Petitioner's Section 12 examiner, Dr. Coe, opined that she suffered from chondromalacia and that the condition was caused by the accident. Respondent's Section 12 examiner, Dr. Neal, examined the actual MRI films themselves and disagreed with the reporting radiologist's view that such a defect even existed on the films. No expert witness has explained this anomaly in the MRI films. The Arbitrator finds that he cannot conclude, based on

the record, that this anomaly was caused by the accident alleged herein, based on the fact that two prior MRI studies failed to show same, and that it suddenly appeared on the third.

Accordingly, Arbitrator finds that only the tibial spine edema and bone bruising were causally related to Petitioner's injury that occurred during the accident of February 13, 2013 and that both had resolved by the time of Dr. Fuentes examination and release of Petitioner on November 11, 2013.

J. Were the medical services provided to Petitioner reasonable and necessary?

When Petitioner returned to work and tried to do her job subsequent to the accident on February 13, 2013, while she was on crutches at the job, she suffered some sort of an occurrence, whether it is a seizure or something else, that sent her to Presence Saint Joseph Medical Center commencing February 20, 2013. She was at that facility until being discharged on February 22, 2013 (P. Ex. 1). She incurred a total medical bill at Presence Saint Joseph Medical Center of $35,474.18. However, the vast bulk of the bills incurred there were for treatment for a possible heart or brain condition. She had an EKG, chest x-rays, head CT scan, brain MRI, and echocardiogram. None of those bills are related to Petitioner's left knee condition. What is related to treatment for her left knee at the hospital include the original x-rays of the left knee on February 20, 2013 ($402.34), the knee MRI on February 21, 2013 ($3,369.39), and the cursory physical therapy evaluation and training performed on February 22, 2013 totaling $732.96. That means that the total of related medical bills at Presence Saint Joseph Medical Center come to $4,504.69. Petitioner is awarded those bills subject to the relevant fee schedule. Respondent is ordered to pay same subject to the applicable fee schedule and is given credit for all sums previously paid hereunder.

With respect to the care at Parkview Orthopaedics Group (Dr. Sampat and Dr. Fuentes), that medical care is all found to be related to Petitioner's accident and is determined to be reasonable and necessary for her care. The total of their charges in the amount of $3,980.00 is awarded to Petitioner and Respondent is ordered to pay same subject to the applicable fee schedule. However, the charges of $742.04 from MK Orthopaedics (Dr. Komanduri) are not to be causally connected to accident alleged herein and are not awarded.

With respect to Primary Care Joliet, it does not appear that Dr. Patel registered any charge for the original office visit which is not reflected in his chart. But, the other visits appear to have been done on a continual monitoring basis only, and once Dr. Sampat was actually doing the orthopaedic care, it does not appear that it was necessary for further care by the primary care physician, Dr. Patel.

K. What temporary benefits are in dispute?

Dr. Sampat kept Petitioner off work from the first time he saw her in the hospital one week after the accident until he saw her in the office on September 6, 2013. At that point, at Petitioner's request he returned her to work limited duty, but the employer would not accept

the light duty restrictions. At the next visit, September 27, 2013, she requested and he gave a full duty return to work slip. Accordingly, Arbitrator finds that Petitioner was entitled to temporary total disability benefits from the day after she went to the hospital (February 14, 2013) through September 27, 2013, at a rate of $435.17 per week for a total of 31-1/7th weeks.

The more difficult question concerns Petitioner's care at Dr. Komanduri's facility. Although Arbitrator has found that the care afforded her at Dr. Komanduri's practice was reasonable, necessary and causally related to the accident (on the basis that she still had the chondromalacia which was work related), the fact is that Dr. Komanduri issued work restrictions for 4 hours per day, 4 days per week with no pushing, pulling, climbing or kneeling (P. Ex. 4, 11/13/15). Those restrictions have not been changed to this day. But, the fact is that Petitioner testified that she was ultimately able to go back to work, first at the Family Dollar Store in November of 2014 then at Cornerstone Services in April of 2016. There is no evidence that Petitioner was unable to look for a job between the limited duty restriction imposed by Dr. Komanduri in November of 2013 and her next employment with Family Dollar in November of 2014. There was no testimony that she attempted to secure employment within those restrictions. Consequently, Arbitrator must conclude that Petitioner is not entitled to TTD subsequent to her return to work slip imposed by Dr. Sampat.

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

Petitioner had a tibial spine bone bruise and edema which, under Dr. Sampat's care, healed. There was residual edema perhaps as a result of the bone bruise In November of 2015 when Dr. Coe examined her, he opined that she should be limited in prolonged standing or walking, and should avoid kneeling or squatting. He opined that there should be a limitation in lifting to the "light" physical demand level (P. Ex. 8, p. 8). Petitioner has apparently been able to return to work with limitations consistent with what Dr. Coe recommendedHOwever, her treating physicians returned her to work full duty, as did the Respondent's IME doctor.

Arbitrator is required to impose the factors of Section 305/8.1b, and herein makes the following findings:

With respect to Section 8.1b(i), the Arbitrator notes that neither party submitted a report under the American Medical Association guidelines. Consequently, Arbitrator affords no weight to that factor.

With respect to Section 8.1b(ii) of the Act (the Occupation of the Injured Employee), it is noted that Petitioner can successfully perform her job duties at Cornerstone Services and, before that, at Family Dollar as a check out cashier under her light duty restrictions. So the Arbitrator affords some weight to that factor.

With respect to Section 8.1b(iii), (the age of the employee at the time of the injury), it is noted that Petitioner was 40 years old at the date of the injury. Accordingly, Arbitrator affords greater weight to this factor.

With respect to Section 8.1b(iv), (the employee's future earning capacity), Arbitrator notes that Schneider Logistics refused to take Petitioner back with the limited duty restrictions imposed by Dr. Sampat. Accordingly, this is may affect her earning capacity; consequently Arbitrator affords a greater weight to that factor.

With respect to Section 8.1b(v), (evidence of disability corroborated by the treating medical records), Arbitrator notes that the Petitioner was returned to work full duty by her treating physicians but still had complaints of pain at the time of the release.Consequently, Arbitrator affords greater weight to this factor.

Taking all of the above factors into account, Arbitrator finds that Petitioner has been disabled to the extent of 5% loss of use of her left leg, amounting to 10.75 weeks at a PPD rate of $391.65.

N. Is Respondent due any credit?

The parties stipulated that to the extent any of Petitioner's medical bills have been paid by health insurance or the Department of Public Aid, Respondent will be given a credit for same. It does appear from Dr. Patel's medical bills that both United Healthcare and the Department of Healthcare and Family Services were invoked for payment. To the extent that any of those bills have been paid by either of those entities, Respondent is given a credit for same in accordance with the applicable fee schedule. Respondent is directed to hold Petitioner harmless from any liability incurred by Petitioner for any of those payments, either by United Healthcare or by the Department of Healthcare and Family Services, to the extent that those bills were related to the medical care she sustained as a result of the accident.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
KANKAKEE

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lucinda Roach,
Petitioner,

vs. NO: 15 WC 41854

Riverside Medical Center,
Respondent.

17IWCC0500

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of nature and extent of Petitoner'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.

The Commission does correct a typographical error in the Arbitrator's Decision; specifically, the cover page and order correctly reference a stipulated average weekly wage of $1,108.31, based on yearly earnings of $57,632.12 (see Arb.Ex. I). However, the first paragraph of the rider noted earnings of $62,129.08 and an AWW of $1,194.79. The rider is therefore amended to reflect the correct stipulated amounts of $57,632.12 and $1,108.31 respectively.

All other findings and awards of the Arbitrator are affirmed.

IT IS THEREFORE ORDERED BY THE COMMISSION that, other than as noted above, the Decision of the Arbitrator filed February 22, 2017 is hereby affirmed and adopted.

17IWCC0500

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $664.99 per week for a period of 16.7 weeks, as provided in §8(e) of the Act, as the injuries sustained caused the loss of use of the right foot to the extent of 10%.

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 $11,200.00. 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 16 2017

Joshua D. Luskin

L. Elizabeth Coppoletti

o-08-02-17
jdl/mp
68

Charles J. DeVriendt

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ROACH, LUCINDA
Employee/Petitioner

Case# **15WC041854**

RIVERSIDE MEDICAL CENTER
Employer/Respondent

17IWCC0500

On 2/22/2017, 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 0.67% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

2208 CAPRON & AVGERINOS PC
DANIEL F CAPRON
55 W MONROE ST SUITE 900
CHICAGO, IL 60603

2389 GILDEA & COGHLAN
EDWARD A COGHLAN
901 W BURLINGTON
WESTERN SPRINGS, IL 60558

STATE OF ILLINOIS)
)SS.
COUNTY OF Kankakee)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
NATURE AND EXTENT ONLY

Lucinda Roach
Employee/Petitioner

v.

Riverside Medical Center
Employer/Respondent

Case # 15 WC 41854

Consolidated cases: _____

17IWCC0500

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 **Christine Ory**, Arbitrator of the Commission, in the city of **Kankakee**, on **July 19, 2016**. By stipulation, the parties agree:

On the date of accident, **June 6, 2015**, 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 **$57,632.12**, and the average weekly wage was **$1,108.31**.

At the time of injury, Petitioner was **68** years of age, ***married*** with **no** dependent children.

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

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**.

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 **$664.99**/week for a further period of **16.7** weeks, as provided in Section **8 (e) 11** of the Act, because the injuries sustained caused **10% loss of use of the right foot.**

Respondent shall pay Petitioner compensation that has accrued from **June 6, 2015** through **July 19, 2016**, 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.

Christine M Ong

Signature of Arbitrator

02/20/2017

Date

FEB 22 2017

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Lucinda Roach	)	
Petitioner,	)	
vs.	)	**No. 15 WC 41854**
Riverside Medical Center	)	
Respondent.	)	**17IWCC0500**

ADDENDUM TO ARBITRATOR'S DECISION
FINDINGS OF FACTS AND CONCLUSIONS OF LAW

This matter proceeded to hearing in Kankakee on July 19, 2016 The parties agree that on June 5, 2015, petitioner and respondent were operating under the Illinois Worker's Compensation or Occupational Diseases Act; that their relationship was one of employee and employer, that petitioner suffered accidental injuries that arose out of and in the course of her employment with respondent and that petitioner's right foot injury was caused by the work accident. They further agree that in the year preceding the injuries, the petitioner earned $62,129.08, and that her average weekly wage was $1,194.79.

The only matter at issue is the nature and extent of petitioner's right foot injury.

FINDING OF FACTS

Petitioner testified she had been employed by respondent since August 6, 1976 as a registered CT scan and radiological technician. On June 6, 2015, while pressing down on a pedal of a cart with her right foot she felt an electric shock go through her foot.

She was first seen for the injury by Dr. Hodulik on June 9, 2015. Her foot was X-rayed, put in a boot and casted for six weeks. She saw Dr. Hodulik through May 3, 2016. She had two MRIs; August 1, 2015 and February 10, 2016. She received twelve sessions of physical therapy. The respondent accommodated her restrictions of sit-down work only. In August, 2015 petitioner took FMLA to care for her husband and officially retired one April 1, 2016.

Her present complaints are pain on the medial side of right foot up to the medial malleolus, which she notices going up and down stairs. She feels a twinge while driving. She wears orthotics and also an oxford-type shoe.

She testified she had no follow up visits scheduled with Dr. Hodulik and is no longer wearing a boot or cast.

She was examined by Dr. Frank Russo and Dr. Timothy Payne at the request of respondent.

Prairie-Rock Foot & Ankle Clinic/Dr. Rebecca Hodulik Records (PX.1).

Dr. Hodulik first examined petitioner on June 9, 2015. X-rays were taken and petitioner was placed in an Unna boot. The diagnosis was tibialis tendinitis.

She followed up on July 1, 2015 with Dr. Hodulik who reported the X-ray from June 9, 2015, showed a very small bone chip of the medial navicular.

On July 22, 2015 a pneumatic CAM walker as applied and an MRI ordered. Petitioner returned to Dr. Hodulik on August 25, 2015. An ankle brace was applied. Petitioner followed up

with Dr. Hodulik on September 16, 2015. At the October 28, 2015 visit, petitioner was custom-fitted for an orthotic.

On December 11, 2015, petitioner reported she completed physical therapy. Another MRI was ordered. She returned on February 23, 2016 to discuss the results of the MRI. She continued to have complaints.

She was last seen by Dr. Hodulik on May 3, 2016 and was to follow up in a few months for the doctor to check on her progress.

The February 19, 2016 MRI showed advanced degenerative changes involving the third tarsometatarsal joint and tendinosis.

Dr. Frank H. Russo October 23, 2015 Report (RX.1)

Dr. Russo examined petitioner at the request of respondent on October 23, 2015. Dr. Russo reviewed records from Dr. Hodulik, which included the MRI report of August 1, 2015. Dr. Russo reported the MRI of August 1, 2015 showed moderate bone marrow edema of the navicular and lateral, intermediate and a portion of the medial cuneiform, which may represent bone bruising or marrow reactive changes. There was evidence of some tenosynovitis and insertional tendinosis of the posterior tibial tendon, as well as sprain of the tibial spring and medial superior.

Dr. Russo's diagnosis was posterior tibial tendonitis/dysfunction. Dr. Russo questioned whether the petitioner's right foot condition was caused by the one incident, but rather was a chronic condition caused by repetitive trauma. Dr. Russo recommended treatment with orthotics and physical therapy.

Dr. Frank Russo January 10, 2016 Report (RX.2)

Dr. Russo was asked to comment on the reasonableness of a repeat MRI. After reviewing the physical therapy records and additional medical records of treatment incurred subsequent to his exam on October 23, 2015, Dr. Russo agreed another MRI was in order to determine if there was any additional pathology.

Dr. Frank Russo March 1, 2016 Report (RX.3)

Dr. Russo authored another report on March 1, 2016 after reviewing the report of the February 19, 2016 MRI. Dr. Russo noted advanced changes to the third tarsometatarsal joint that had progressed since the previous MRI. The MRI showed improvement of the mild insertional tendinosis of the posterior tibial tendon and adjacent medial subcutaneous inflammation from the previous MRI. Dr. Russo noted the bone marrow edema in the navicular talus, posterior tibial tenosynovitis and medial soft tissue edema of the ankle were resolved compared with the previous MRI.

Dr. Russo believed the advanced changes to the third tarsometatarsal joint is an incidental, finding unrelated to petitioner's original complaint.

Dr. Timothy Payne March 18, 2016 AMA rating report (RX.4).

Dr. Payne performed an impairment rating evaluation on March 18, 2016. Based upon his evaluation, Dr. Payne provided an impairment rating of 1% of her lower extremity, or 1% body as a whole.

CONCLUSIONS OF LAW

The Arbitrator adopts the Finding of Facts in support of the Conclusions of Law.

In support of the Arbitrator's decision with regard to the nature and extent of injury, the Arbitrator finds the following:

Petitioner sustained a small bone chip fracture of the medial navicular and tibial tendinitis as a result of the work accident of June 6, 2015. She underwent casting, physical therapy, but no surgery.

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

With regard to subsection (i) of §8.1b (b) the Arbitrator notes that on March 18, 2016 Dr. Payne provided a permanent partial disability impairment rating of 1% of the lower extremity and 1% of the person. The Arbitrator gives some weight to this factor.

With regard to (ii) of §8.1b (b) the occupation of the injured employee, the Arbitrator notes petitioner was employed as a CT scan and radiological technician for forty years. As such, she was required to be on her feet a significant amount of time. Petitioner was placed on sedentary work after the accident and elected to voluntarily retire for unrelated reasons prior to receiving a full-duty release. Therefore, the Arbitrator gives some weight to this factor.

With regard to (iii) of §8.1b (b) the age of the employee at the time of the injury was 68 years of age, and was 69 at the time she testified. Therefore, the Arbitrator gives little weight to this factor.

With regard to (iv) of §8.1b (b) the employee's future earning capacity, the Arbitrator notes respondent had accommodated petitioner's restrictions at the same rate of pay. Petitioner voluntarily retired from her employment with respondent for unrelated reasons. The Arbitrator therefore gives little weight to this factor.

With regard to (v) of §8.1b (b) evidence of disability corroborated by the treating medical records, the Arbitrator notes the medical records substantiate petitioner had a small bone chip of the medial navicular and tibial tenosynovitis. Petitioner was prescribed and wears orthotics. At her last visit with Dr. Hodulik on May 3, 2016, petitioner had mild swelling of the ankle and mild tenderness on palpation. The Arbitrator therefore gives minimal weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of right foot § 8 (e) 11 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

FRANK KROLL,

Petitioner,

vs.

NO: 15 WC 29002

CITY OF CHICAGO,

17IWCC0501

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by Respondent herein and notice given to all parties, the Commission, after considering the issues of the prospective medical language contained in the arbitration decision and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof. 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 Order contained within the Decision of the Arbitrator ordered Respondent to "authorize and pay for the medical treatment recommended by Dr. Nigro on June 1, 2016. Specifically, Petitioner is awarded a right shoulder arthroscopic debridement with subacromial decompression and distal clavicle excision, and any and all reasonable and necessary rehabilitative care thereto, pursuant to Section 8(a)." Respondent filed its Petition for Review and then articulated in its Statement of Exceptions that the following language as written in the Decision of the Arbitrator, "and any and all reasonable and necessary rehabilitative care thereto," should be stricken from the Order. The Commission finds no reason to disturb the Decision of the Arbitrator as it was written.

The Commission finds the adoption of Respondent's proposed language would unnecessarily deny Petitioner timely rehabilitative care and put his recovery at risk if he were to

first file a petition with the Commission and then undergo one or more hearings before obtaining continued care. The Decision of the Arbitrator specifically authorized "all reasonable and necessary rehabilitative care." If at any time following the awarded surgeries Respondent concludes Petitioner is obtaining rehabilitative care that is either unreasonable or unnecessary, Respondent is free to file the appropriate motion with the Commission to contest any care it deems offensive.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 22, 2016, 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 18 2017
KWL/mav
O: 07/11/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

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

KROLL, FRANK
Employee/Petitioner

Case# **15WC029002**

CITY OF CHICAGO
Employer/Respondent

17IWCC0501

On 9/22/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0154 KROL BONGIORNO & GIVEN LTD
MICHAEL BRANDENBERG
120 N LASALLE ST SUITE 1150
CHICAGO, IL 60602

0010 CITY OF CHICAGO
STEPHANIE LIPMAN
30 N LASALLE ST SUITE 800
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)

Frank Kroll
Employee/Petitioner

v.

City of Chicago
Employer/Respondent

Case # **15** WC **29002**

Consolidated cases: **n/a**

17IWCC0501

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 21, 2016**. 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 _____

17IWCC0501

FINDINGS

On the date of accident, **June 2, 2015**, 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 **$71,667.96**; the average weekly wage was **$1,378.23**.

On the date of accident, Petitioner was **41** years of age, ***married*** with **2** dependent children.

Respondent shall be given a credit of **$393.80** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$393.80**.

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 $918.82/week for 6/7 weeks, representing the period commencing June 3, 2015 through June 8, 2015, as provided in Section 8(b) of the Act. The Arbitrator notes that the first 3 days of lost time are non-compensable pursuant to the Act, as Petitioner did not miss 14 days in total. Respondent shall be given a credit of $393.80 for temporary total disability paid to Petitioner.

Respondent shall authorize and pay for the medical treatment recommended by Dr. Nigro on June 1, 2016. Specifically, Petitioner is awarded a right shoulder arthroscopic debridement with subacromial decompression and distal clavicle excision, and any and all reasonable and necessary rehabilitative care thereto, 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.

17IWCC0501

FINDINGS OF FACT

The disputed issues in this matter are: 1) causal connection; and 2) whether Petitioner is entitled to prospective medical treatment. *See,* AX1.

Petitioner's Testimony and Medical Records

At the time of accident, Frank Kroll ("Petitioner") was a 41-year-old driver employed by the City of Chicago. On June 2, 2015, he was depositing a recycling load into the truck. He testified that the loads will usually get lifted by the truck and the contents tipped out, but sometimes the load will stick. He then has to jar it loose using a stick with a hook on the end. On June 2, 2015, Petitioner used the stick to pull on a stuck load that contained heavy television sets. As he yanked hard on the load, his arm jerked back and he heard a pop and felt pain in his right shoulder.

The next morning on June 3, 2015, Petitioner was examined by Dr. Nagib Ali at MercyWorks. The right shoulder exhibited positive impingement and tenderness over the anterior aspect. Dr. Ali diagnosed Petitioner ad having a right shoulder strain and recommended that he remain off work. PX1.

On June 8, 2015, Petitioner was examined by Dr. Homer Diadula at MercyWorks. The diagnosis remained right shoulder strain and at Petitioner's request, Dr. Diadula released him to return to work full duty; which he did on June 9, 2015. PX1.

On June 16, 2015, Petitioner was again examined by Dr. Diadula, exhibiting right shoulder tenderness and positive empty can and scapularis lift tests. Dr. Diadula prescribed an MRI of the right shoulder. PX1.

On July 1, 2015, Petitioner underwent an MRI of the right shoulder at Chicago Ridge Medical Imaging. The scan revealed marked hypertrophic arthropathy of the acromioclavicular ("AC") joint with a type II acromion process impressing upon the underlying supraspinatus musculotendinosis junction; associated supraspinatus tendinopathy without a discrete tear; trace sub-deltoid bursitis; rotator cuff grossly intact; glenoid labrum grossly intact. PX2.

On July 7, 2015, Dr. Diadula diagnosed Petitioner with a right shoulder strain and impingement syndrome. He referred Petitioner to Dr. Phillip Nigro, an orthopedic specialist, at Bone & Joint Physicians. PX1.

On July 9, 2015, Petitioner was examined by Dr. Nigro, who found that Petitioner's right shoulder exhibited mild anterior tenderness and positive O'Brien's and Speed's tests. His diagnosis was right shoulder subscapularis tendonitis. PX2.

On July 30, 2015, Petitioner again presented to Dr. Nigro, exhibiting pain in the right shoulder when crossing his body with the right arm; positive O'Brien's and Hawkin's tests; and tenderness at the anterior lateral acromion and the deltoid. Dr. Nigro diagnosed Petitioner with right shoulder

impingement and biceps tendinitis, and he administered an injection to the biceps groove. On September 2, 2015, Dr. Nigro noted that Petitioner's right shoulder exhibited positive O'Brien's for AC joint tenderness, positive cross-body adduction test, and significant AC joint tenderness. The diagnosis was right AC joint arthritis, and Dr. Nigro administered an injection to Petitioner's right AC joint. PX2.

On December 12, 2015, Dr. Nigro administered another injection to Petitioner's right AC joint. On March 30, 2016, Petitioner saw Dr. Nigro again, reporting pain and difficulty at work, especially when shifting in the work truck. His right shoulder exhibited severe tenderness at the AC joint and a bony prominence, positive cross-body adduction test, and good rotator cuff strength that produces pain. The diagnosis was right AC joint degenerative joint disease with shoulder impingement. Dr. Nigro recommended arthroscopic debridement, subacromial decompression and distal clavicle excision. PX2.

On April 25, 2016, Petitioner was examined by Dr. Gregory Primus, a Section 12 Examiner hired by Respondent. Upon examination, Dr. Primus noted tenderness at the right AC joint and long head biceps, pain at the end ranges of motion, and positive cross-arm, Speed's, Obrien's, and Yergason's tests. Dr. Primus opined that the July 1, 2015 MRI showed evidence of severe AC joint arthrosis with bone cysts and impingement with increased signal changes around the thickened capsule, distal tendinitis of the supraspinatus with a possible 2mm partial articular tear; a small sharp spur noted under the anteriolateral acromium; and increased fluid in the bicipital groove.

Dr. Primus further opined that Petitioner suffered a right shoulder strain with slight irritation of the biceps tendon and impingement, but that the AC joint pain was unrelated to the work injury. Dr. Primus did not recommend further treatment for the strain and impingement without first undergoing a physical therapy regiment. "Based on the medical records we had available for review, it does not appear that the AC joint pain, which is his major compliant and driving pain generator, is related to the work injury, but more so a manifestation of this pre-existing arthritic condition. This is especially more likely given the fact that it is not mentioned in the medical records until April 2016, and there was no specific mention of AC joint pain and treatment in the medical encounters immediately and soon after his work injury". RX2.

On June 1, 2016, Dr. Nigro re-examined Petitioner, noting positive cross-body adduction test and tenderness in the right AC joint. Dr. Nigro again strongly recommended right shoulder surgery, including subacromial decompression and distal clavicle excision. Dr. Nigro opined that Dr. Primus' report is an inaccurate representation of Petitioner's medical records, noting that Petitioner received AC joint treatment on September 2, 2015, not beginning April 4, 2016; as claimed in Dr. Primus' report. He further opined that Petitioner has undergone substantial nonsurgical treatment of his right shoulder symptoms, which are directly related to his work injury. Petitioner testified that he wanted to undergo the surgery recommended by Dr. Nigro so that he can get relief from his constant pain. PX2.

Petitioner is right-hand dominant and currently experiences constant, throbbing pain in his right shoulder. He has increased pain in his right shoulder with day-to-day activities such as pouring a

glass of milk, playing catch with his son and overhead household chores. He wakes up multiple times during sleep each night when he rolls onto his right shoulder and feels pain. While driving at work, he gets increased soreness and pain when shifting gears of a semi-trailer with his right hand. When he has to spray weeds, he can only use his right hand for a limited time and he mostly uses his left hand. He applies ice to his right shoulder when it becomes painful.

CONCLUSIONS OF LAW

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

Petitioner testified that prior to the accident on June 2, 2015, he was not having any problems with his right shoulder. Immediately after the recycling load came loose and pulled his right arm back, he heard a pop and felt pain in the right shoulder. The medical records are consistent with this history. PX1, PX2.

Respondent's Section12 Examiner, Dr. Primus, opined that Petitioner sustained a right shoulder strain and irritation of the biceps with impingement as a result of his work accident. Dr. Primus stated that Petitioner's right AC joint symptoms are related to a pre-existing condition, not the work accident based on his review of the medical records in which he notes no mention of AC joint pain until April of 2016. RX2.

As Dr. Nigro points out in his June 1, 2016 treating record, Petitioner began exhibiting AC joint symptoms as far back as September 2, 2015, including an AC joint injection at that date of service. Dr. Nigro opined that the substantial treatment Petitioner has undergone and the recommended surgery for his AC joint symptoms are directly related to his work injury in June of 2015. It is evident that Dr. Primus either did not review all of Petitioner's treating records as he ignored the treatment on Petitioner's right AC joint prior to April 4, 2016.

The Arbitrator has had the opportunity to review the medical evidence and the testimony of the witness. The Arbitrator finds the opinions of Dr. Nigro to be more persuasive than those of Dr. Primus. The Arbitrator finds a causal connection between Petitioner's present condition of ill-being in the right shoulder, including the AC joint, and the work accident of June 2, 2015.

K. Is Petitioner entitled to any prospective medical care?

Based on the Arbitrator's findings in Section "F" above, Petitioner's current medical condition is related to his work accident. The treating physicians have not found Petitioner to be at maximum medical improvement. Dr. Nigro has consistently recommended, i.e. on three occasions, that Petitioner undergo surgery on the right shoulder, including arthroscopic debridement, subacromial decompression and distal clavicle excision. Dr. Primus, Respondent's Section 12 Examiner, does not recommend surgery for Petitioner's AC joint symptoms until he undergoes a full, formal course of physical therapy. However, as Dr. Nigro points out, Petitioner underwent and failed significant conservative treatment including four injections and a home exercise program. Furthermore, it is

evident that Dr. Primus did not review or chose to ignore the medical records documenting that treatment.

Petitioner testified that he currently experiences constant, throbbing pain in his right shoulder that gets worse with activities such as shifting in the work truck, spraying weeds, overhead chores. He has difficulty sleeping at night and no longer plays catch with his son. When the pain increases, he has to ice his right shoulder. He testified that he wants to get the surgery recommended by Dr. Nigro in order to relieve the constant pain in his right shoulder.

The Arbitrator finds the treatment recommendations of Dr. Nigro to be reasonable and necessary and orders the same. Respondent shall pay for the prospective medical treatment recommended by Dr. Nigro on June 1, 2016; and any rehabilitative treatment that is reasonable and necessary.

17IWCC0501

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
15WC29002
SIGNATURE PAGE

Signature of Arbitrator

September 22, 2016
Date of Decision

SEP 22 2016

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

Gary L. Boyle,

Petitioner,

vs. NO: 14WC 21860

Caterpillar, Inc.,

Respondent.

17IWCC0502

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 accident, medical, 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 October 20, 2016 is hereby affirmed and adopted.

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

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

17IWCC0502

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $14,700.00. 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 2017
o081517
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BOYLE, GARY L
Employee/Petitioner

Case# **14WC021860**

CATERPILLAR INC
Employer/Respondent

17IWCC0502

On 10/20/2016, 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 0.47% 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:

0047 McCARTHY ROWDEN & BAKER
HUGH H ROWDEN
243 S WATER ST
DECATUR, IL 62523

2994 CATERPILLAR INC
MARK M FLANNERY
100 N E ADAMS ST
PEORIA, IL 61629-4340

17IWCC0502

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

GARY L. BOYLE
Employee/Petitioner

v.

CATERPILLAR, INC.
Employer/Respondent

Case # **14** WC **21860**

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 **Springfield**, on **August 19, 2016**. 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 **06/04/14**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$31,054.40**; the average weekly wage was **$597.20**.

On the date of accident, Petitioner was **29** years of age, *married* with **2** dependent children.

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

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

Respondent shall be given a credit of **$0** for TTD, **$0** for TPD, **$0** for maintenance, and **$1,312.95** for other benefits, for a total credit of **$1,312.95**.

Respondent is entitled to a general credit for any medical bills paid by its group medical plan for which credit is allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay reasonable and necessary medical services of **$8,152.83,** subject to the Medical Fee Schedule, as provided in Sections 8(a) and 8.2 of the Act. Respondent shall be given a general credit amount of 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.

Respondent shall pay Petitioner temporary total disability benefits of **$398.13/week** for **4 6/7th weeks**, commencing **June 5, 2014**, through **July 6, 2014,** as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of **$358.32/week** for **12.5 weeks**, because the injuries sustained caused the **2.5% loss of the person as a whole,** as provided in Section 8(d)2 of the Act.

Penalties and Attorney's Fees are denied.

Respondent shall pay Petitioner compensation that has accrued between **June 4, 2014** and **August 19, 2016** and shall pay the remainder of the award, if any, in weekly installments.

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

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

Signature of Arbitrator

October 17, 2016
Date

ICArbDec p. 2

OCT 20 2016

FINDINGS OF FACT AND CONLCUSIONS OF LAW

The Arbitrator finds:

Petitioner reported to work for Respondent on June 4, 2014. According to Respondent's Impact Sensor Data Log for that date Petitioner logged into his forklift truck at 7:09 a.m. and commenced his safety checklist. He then logged off at 7:35 a.m. He logged on again as of 7:38 a.m. and logged off at 7:45 a.m. He switched on again at 7:46 a.m. and logged off at 8:23 a.m. Following that he logged on at 8:24 a.m. and off at 8:39 a.m. He then logged on again at 8:40 a.m. and off at 8:42. a.m. (RX 7)

At 9:00 a.m. on June 4, 2014 Petitioner was given a Medical Pass to report to Respondent's Medical Department. According to the Pass, Petitioner had "bumped head and." He arrived at Respondent's Medical department at 9:06 a.m. (RX 1, p. "3") Nurse Darci Walker completed an Initial Licensed Health Care Professional Incident/Injury Form. She noted that the injury occurred on June 4, 2014 at 7:30 a.m. when Petitioner hit his head. He complined of pain rated an "8/10" in his upper neck. Ms. Walker wrote that Petitioner was taking a wood pallet out with a fork lift truck. Pallet pieces fell off and Petitioner ran into it with his truck. He left the seat and hit the top of his head on the roof of the truck. Petitioner complained of nausea, had vomited twice, and was noting sharp pain in both ears along with neck pain and blurry vision. He denied any loss of consciousness. Petitioner was transported to St. Mary's per Dr. Fabrique's order. At his request, Petitioner was given a medical collar. (RX 1, p. "6", "10") Petitioner also completed a pain drawing on June 4, 2014 showing moderate complaints of pain in his neck, thoracic spine, and bilateral hips. (RX 1, p. "17") According to the "Progress Note" completed at 9:35 a.m. that same date the emergency room nurse at St. Mary's was advised to call Respondent's medical department and update personnel before doing anything medically. (RX 1, p. "10")

Petitioner was transported to St. Mary's via ambulance between 9:19 a.m. and 9:24 a.m. According to the narrative report, the ambulance was called to Respondent due to a male patient having a possible head injury. Upon arrival, Petitioner was found sitting in the medical department alert and in mild distress. According to the history, Petitioner was operating a forklift that drove over an object that caused the patient to go upward and strike his head on the root. Petitioner was wearing a safety hat and denied being knocked out. Petitioner was ambulatory at the scene and complaining of head pain and neck discomfort. Examination of Petitioner's neck showed no tenderness, deformity, or obvious injury. His pelvis and extremities were normal. Petitioner was transported without incident. (PX 1)

Upon presenting to St. Mary's at approximately 9:54 a.m., Petitioner gave a history of having been driving a forklift earlier in the morning when he went to run over some tracks and a piece of wood fell off a pallet and Petitioner hit it with the forklift causing him to be jostled upwards and sideways. Petitioner hit the top of his head on the roof the forklift's cab and saw stars but didn't lose consciousness. Petitioner reported getting out of the cab to move the obstruction. Approximately one hour later Petitioner noted some nausea along with neck and low back pain radiating to his hips

bilaterally. Petitioner was noted to have a history of anxiety for which he was prescribed Xanax, his last dose having been taken three days earlier. Petitioner estimated his pain level at an "8/10." Petitioner also acknowledged a history of musculoskeletal problems (lower back pain) which would "come and go." While at St. Mary's, Petitioner underwent a CT of his head after hitting the top of his head on a forklift. The CT was negative. A cervical spine x-ray was taken due to complaints of pain in the neck and back radiating to Petitioner's shoulders. When compared to an earlier one taken on May 11, 2011, the impression was mild scoliosis. (RX 1; RX 3; PX 2B; PX 2A) Petitioner was diagnosed with musculoskeletal pain and discharged in stable condition. He was also given Ibuprofen 4 and told he could use Tylenol and ice/heat his neck and back for the next couple of days if needed. He was referred to St. Mary's Occupational Health, through his employer, for a visit on June 5, 2014. Dr. Barnell noted that someone from Respondent called the charge nurse and informed her that it had re-enacted the accident and couldn't reproduce the prior results. The doctor noted, "Apparently, the patient is currently on disciplinary action for another incident." Petitioner was advised he could return to work. (PX 2A)

Petitioner returned to Respondent's Medical Department at 1:40 p.m. after being discharged from St. Mary's. According to the "Progress Note" dated "6/4/13" and completed by Nurse Jerry Cunningham, Petitioner was ambulating well, moving all extremities well and speaking with other employees casually while leaned back in a chair with his hands clasped behind his head and neck. Petitioner displayed no outward signs of pain while in the medical department. In speaking with Petitioner, he stated his neck pain was "8/10." He had also been given an injection of Toradol for his hip pain. The nurse asked Petitioner about the hip pain because he was unaware of it initially to which Petitioner responded, "Yeah, I don't know, I just know that my hips started hurting when I got here." and "Maybe it was the walk up here." Petitioner described his hips as being "on fire." The nurse asked Petitioner how he injured his hip in the incident and he could not give him a reason. He wrote, "I confirmed with the employee that he had struck the top of his head when driving his fork lift truck and this was why he came to medical, He stated 'yes.'" (RX 1) Petitioner also told the nurse that he was going to go to his own doctor. When reminded that he had been fully checked out at the emergency room, he replied "Yeah, but they only checked from here up," motioning with his hand indicating the neck level and above. The nurse noted that Petitioner showed no outward signs of physical stress and he felt his actions were consistent with that of a person in very little, if no, distress. Dr. Fabrique was consulted and it was determined that Petitioner could return to his regular duty but should follow up with the nurse on June 5, 2014 after doing his stretches. All radiology reports were noted to have been negative. (RX 1, pp. "9-10")

Petitioner completed a Caterpillar Employee Incident Report on June 4, 2014. He reported that he was taking pallets for "797" to salvage and was crossing tracks on the west side of B Building when the forklift "jumped/[?] wood from pallet came or went under the fork lift truck" and Petitioner bounced up and hit/bumped head. Petitioner reported bouncing up twice and becoming nauseous later. Petitioner reported telling his boss and being sent to Medical and then sent to St. Mary's. Petitioner further reported that there were witnesses. He could not identify their names but identified them as the people that clean up a lot (a "black guy - white ford truck") Petitioner noted his lower back, neck, upper back, and hips hurt. He denied any prior injuries to those body parts. (RX 1, p. "5")

According to the summary completed in Respondent's Medical Department after Petitioner's examination Petitioner estimated the time of the accident at 7:30 a.m. According to the Nurse's Note, Petitioner was taking wood pallets out with a fork lift truck. The pallet pieces fell off and he ran into it

with his truck. He left the seat and hit the top of his head on the roof of the truck. Petitioner complained of nausea reporting he had vomited two times. He also reported sharp pain in both ears and neck pain with blurry vision. He denied any loss of consciousness. The nurse noted that Dr. Fabrique had ordered that Petitioner be seen at St. Mary's and Petitioner had, indeed, been transported there. Petitioner was released to return to work at approximately 2:00 p.m. (RX 1, p. "2")

Dr. Fabrique authored a progress note on June 5, 2013 [sic] He noted that Petitioner had a 40 minute delay of report post-accident, there was no evidence of the reported emesis, Petitioner's seat belt was functional per Weise, the impact alarm was not reported, and the impact sensor was functioning normally. Therefore, Dr. Fabrique was of the opinion that it was more likely than not that the incident reported by Petitioner did not occur as reported. Petitioner's incident was deemed non-occupational. (RX 1, p. "9")

Petitioner presented to Dr. Cavanagh on June 5, 2014 with the chief complaint of bilateral hip pain. Petitioner reported that the day before, while at work, he was driving his fork lift and ran over some objects/materials on the floor which caused him to bump his head and push his body forward, shaking his body up. Afterwards, he felt nauseated, then vomited, followed by pain and a burning sensation. Petitioner complained of a burning sensation in the back of his neck radiating to his right shoulder and down to his upper right arm. He also reported pain in the middle of his upper back, pain and a burning sensation in his hips, and left upper thigh pain. Dr. Cavanagh noted that the primary pain appeared to be in the muscles around the middle of Petitioner's back with no real radiation down into his legs. Petitioner's nausea was somewhat better. Petitioner was noted to have been wearing a helmet and had no bruising or pain in his head. On examination Petitioner had no tenderness of the cervical, thoracic or lumbar spine. He had some muscle pain and tenderness about the posterior cervical muscles and thoracic back muscles around the mid-scapular level. He also had some tenderness, noted as "minimal" around the lumbar back. Straight leg raising was normal bilaterally. Petitioner was diagnosed with an acute back strain and concussion and was given cyclobenzaprine, naproxen, and hydrocodone to take. (PX 3A)

In a note dated June 5, 2014 Dr. Cavanagh took Petitioner off work from June 4, 2014 through June 8, 2014. (PX 6)

Dr. Cavanagh re-examined Petitioner on June 9, 2014 at which time Petitioner noted ongoing mid-back pain, lower back pain, and bilateral hip (right greater than left) pain. Petitioner's primary pain was down both sides of his low back going into his buttocks and upper thighs. Aggravating activities included standing, walking or certain movements. Lying down or sitting helped. Petitioner, on exam, had normal range of motion of both hips, tenderness of the lumbar paraspinal muscles, and normal range of motion of his thoracic and lumbar spine. Some pain with rotation of the low back was noted. Petitioner's diagnoses were improved concussion and unchanged back stain. Petitioner was to return in one week. (PX 3A)

In a note dated June 9, 2014 Dr. Patrick Cavanagh stated that Petitioner was unable to work from June 4, 2014 through June 22, 2014. (RX 1; PX 6)

Petitioner returned to Dr. Cavanagh on June 16, 2014 reporting ongoing low back pain rated at "8/10" and pain radiating down his left buttocks and leg. He also reported a deep, burning sensation in his left buttock and upper posterior thigh and occasional left ankle and knee weakness when walking.

The pain had been interfering with sleep until the oxycodone began controlling the pain. His exam revealed "quite marked" tenderness to palpation of the lower spine around L5/S1 and pain with flexion and rotation of the back. Straight leg raising was 70 degrees on the right and 80 degrees on the left with a notation of back pain when raising the right leg. Petitioner's diagnosis was changed to lumbar radiculopathy. Petitioner was advised to return in two weeks. (PX 3A)

On June 16, 2014 Dr. Cavanagh issued a "To Whom It May Concern" letter regarding his treatment of Petitioner which dated back to June 18, 2013. Dr. Cavanagh noted that he had access to Petitioner's medical records going back to August 19, 2008 and that during that time he found no history or mention of any back problems. Dr. Cavanagh went on to state that on June 4, 2014 Petitioner was driving a forklift truck when a piece of wood fell in front of the wheel and he ran over it causing him to jolt upwards and sideways. His head hit the top of the cab and he twisted his back. He was sent to St. Mary's, checked out, and given medication. Petitioner then presented to the doctor on June 5, 2014 complaining of back pain with radiation into his legs. It was very painful for him to move around and since then he has been on anti-inflammatory medication, pain killers, and muscle relaxants with no real improvement. His current complaints include pain across his lower back going into his left buttock and thigh and radiating down his leg with occasional weakness in his left knee and ankle when walking. Dr. Cavanagh noted that movements of Petitioner's back, especially flexion and rotation, were extremely painful and while gait and leg strength seemed grossly normal, straight leg raising was diminished on the right side to 70 degrees and 80 degrees on the left with "quite marked" back pain. Dr. Cavanagh felt Petitioner's complaints and injuries seemed consistent with his account of the accident and since he has no history of back problems prior to the accident the doctor was convinced the problem most directly related to Petitioner's work accident. (PX 3B)

At Dr. Cavanagh's request Petitioner underwent a lumbar spine x-ray on June 16, 2014. It showed mild degenerative changes and mild scoliosis. (PX 4A)

On June 18, 2014 Petitioner's attorney wrote to Respondent's attorney asking him to investigate the claim and reassess compensability, including Respondent's liability for TTD benefits. (PX 8)

Petitioner returned to see Dr. Cavanagh on June 19, 2014 stating that he needed to go back to work for financial reasons but wondered if he would need restrictions. Petitioner reported his back was slowly starting to improve and he was able to engage in some yard work over the last few days. He had bent down to lift his three year old child and his back popped and, thereafter, he was feeling somewhat better. Petitioner still complained of upper mid back pain and a burning sensation as well as left buttocks and thigh pain. Nevertheless Petitioner felt he could cope with most of his regular job except for the heavy lifting and forklift driving. Petitioner still had some tenderness in his mid to lower thoracic and lumbar spine on exam. Straight leg raising was a little restricted on the left. Dr. Cavanagh noted both of Petitioner's lumbar conditions (strain and radiculopathy) were improving. (PX 3A)

In a note dated June 19, 2014 Dr. Patrick Cavanagh stated that Petitioner was unable to work from June 4, 2014 through June 22, 2014. He added that Petitioner could work with restrictions of no bending, no lifting over 20 pounds, and no forklift driving. Those restrictions were to remain in effect until July 6, 2014. (RX 1; PX 6)

On June 23, 2014 Petitioner telephoned Dr. Cavanagh's office requesting a note for work "stating work related injuries." The letter was to be faxed to Respondent. (PX 3A)

Dr. Cavanagh authored a letter to "To Whom It May Concern" on June 23, 2014 noting Petitioner had presented with a history of injuring his back at work. At that time Petitioner had spasm and tenderness down the right paraspinal muscles extending from about the mid-thoracic area to the right lower lumbar area. He also had "quite marked tenderness" in his lower lumbar spine and a burning sensation in his left buttock extending down the back of his left leg to about mid-thigh level. X-rays showed no injury. Dr. Cavanagh noted that "this" has resolved quite markedly to the point where he has some tenderness of the right thoracic paraspinal muscles in the mid-thoracic area and tenderness in the lower lumbar area. Petitioner still had some tenderness in the left buttock but that, too, was improving. Dr. Cavanagh felt Petitioner should be able to perform his regular job in another week or two. (RX 1; 3B)

Petitioner was again seen in Respondent's Medical Department on June 23, 2014 for a return to work evaluation. Nurse Darci Walker examined Petitioner. She noted that Petitioner was complaining of lower back pain and left hip pain which was better but still hurt. In particular Petitioner noted a burning pain in his left lower back when bending over. He could twist side to side without difficulty. He had a release for return to work from Dr. Cavanagh for June 23, 2014. Petitioner was taking narcotic medications and had restrictions from Dr. Cavanagh. Petitioner was released to return to work per the restrictions and told to return on July 3, 2014 for a re-evaluation. (RX 1, p. "7") Dr. Fabrique also examined Petitioner on that date for a non-occupational return to work evaluation. He noted Petitioner was complaining of lower back pain and left-sided hip pain. Dr. Cavanagh's restrictions were noted. Petitioner was not released to return to work. (RX 1, p. "9")

Petitioner completed a pain drawing on June 23, 2014 noting ongoing mild pain in the left lower back/buttocks region. He did not indicate any neck or upper/thoracic spine complaints or left hip complaints. (RX 1, p. "24")

Petitioner signed his Application for Adjustment of Claim herein on June 23, 2014. (AX 2)

On June 27, 2014 Petitioner applied for disability benefits through Respondent. (PX 3C) Petitioner stated he was unable to return to work as of June 5, 2014 due to work restrictions. He claimed a work injury while driving a forklift truck outside of B Building when wood fell off a pallet and he ran over it with his truck. Dr. Cavanagh completed a Physician's Statement for disability benefits on June 27, 2014. He noted that he had begun treating Petitioner on June 5, 2014 for an acute back strain. Petitioner's objective finding included tenderness in the right thoracic and lumbar paraspinal muscles and tenderness in the lower lumbar spine. Petitioner was unable to work at the present time and it was believed he could return to work around July 6, 2014. If restrictions could be met, he could return to work. (RX 1; PX 3C)

Petitioner was again examined in Respondent's Medical Department on July 3, 2014. At that time Petitioner's chief complaint was low back pain. He was examined by Nurse Thomas. Petitioner reported being on a forklift truck on June 4, 2014 when the truck became stuck on a piece of wood and Petitioner hit his head which caused his back to ache. He had been diagnosed with a back strain. Petitioner was now released to return to work with no restrictions. His range of motion was noted to be normal. Petitioner denied any pain other than a mild ache he rated at "4/10" which would be precipitated by long distance walking or sitting for too long. Petitioner felt able to return to work. He was to be examined by Dr. Fabrique. (RX 1, p. "8")

Petitioner completed another pain drawing on July 3, 2014 noting broader complaints and symptoms in the lower back/buttocks region bilaterally. Petitioner noted mild pain when walking long distances, up and down stairs, and sitting for too long. (RX 1, p. "26")

Petitioner was seen by Dr. Fabrique on July 3, 2014 noting ongoing low back pain of a "4/10" but otherwise feeling ready to return to work and feeling able to perform all job requirements. He denied any symptoms in his extremities. Petitioner's gait was normal and he displayed no evidence of neuropathy. He was released to return to work with restrictions of "905 [no night shift work] and 910 [no second shift work]." (RX 1, p. "9")

On July 14, 2014 Dr. Cavanagh's office received a call from Cuna Mutual Group regarding Petitioner's return to work date and restrictions. Apparently Petitioner was claiming he was unable to work or pay a loan due to his disability. LPN Sheets noted that the carrier was advised of a previous work note stating Petitioner had no restrictions after July 6, 2014 and if Petitioner still was in pain, he needed to call the doctor. (PX 3B)

On July 16, 2014 Petitioner's attorney sent another letter to Respondent's attorney regarding Petitioner's claim. In the letter, Petitioner's attorney outlined the events of June 4, 2014 along with treatment through Dr. Cavanagh. He further noted that Petitioner had returned to Respondent's Medical Department on June 23, 2014 to return to work per Dr. Cavanagh at which time he was again advised that his injuries were "non-occupational" and that he could not return to work with the restrictions imposed by the doctor. Petitioner was also told that his supervisor, Dan Daugherty, denied any knowledge that Petitioner had experienced nausea and vomited shortly after his accident. He also referenced that Petitioner was examined by Respondent's doctor on July 3, 2014 at which time he was authorized to return to work on July 7, 2014. According to counsel, when Petitioner returned to work on July 7th his desk and chair had been removed. He worked all day albeit without pain medication and was experiencing severe low back pain at the end of his shift. According to the letter, Petitioner spoke to his supervisor, Mr. Daugherty, and "reported the statement by the medical department nurse, Jeremy Chance, that Mr. Daugherty had not witnessed Petitioner vomiting on June 4, 2014, and reported to the supervisor that the nurse had 'treated me like an asshole. Excuse me. A criminal.' Apparently Dan Daugherty is now denying that he observed [Petitioner] vomit on June 4, 2014 although when the vomiting occurred, the supervisor told [Petitioner] not to clean/remove the vomit, that another work would complete this task. [Petitioner] did clean and remove the vomit before going to the medical department, as directed by the supervisor." Counsel further contended that the next day Petitioner's supervisor took him aside and advised him he was being suspended indefinitely for violating Respondent's Code of Conduct by "swearing for an innocuous comment which was not profane." The alleged profanity was the statement by Petitioner that the nurse treated him "like an asshole. Excuse me. A criminal." Petitioner was being suspended indefinitely without pay. (PX 8)

Petitioner's attorney went on to note that Petitioner had no low back or hip pain before June 4, 2014 and had never filed a workers' compensation claim against Respondent. He further noted the circumstances under which Petitioner's claim was deemed non-compensable but took issue with the notation in Respondent's medical records that Petitioner was on a disciplinary watch at the time of his accident as Petitioner had never been notified he was on a disciplinary watch and, to his knowledge, he never received any disciplinary action for his conduct with Respondent prior to the accident. He asked that a video of the occurrence be saved as there were security cameras located outside the building

where the incident occurred and that Respondent's counsel investigate matters. (PX 8)

Petitioner returned to Dr. Cavanagh's office on August 13, 2014 regarding low back pain rated a "4/10." Petitioner reported that the thoracic pain going into his shoulder seemed to have settled down but his chief complaint remained chronic lumbar back pain. The doctor noted, "Had this for several years now but was aggravated by his recent accident." Petitioner's pain seemed to be across the lower lumbar spine without radiation. He was working normally and doing a lot of walking at work. At night he noticed a lot of pain when sitting. Petitioner was noted to have a long history of chronic anxiety and panic attack disorders. On exam, he had normal range of motion of his spine. Some moderate tenderness over his lower back and SI joints was noted. He was diagnosed with lumbar back pain and anxiety/depression. (PX 3A)

Petitioner presented to DMH Express Care North on September 10, 2014 regarding back, shoulder, and neck pain of four days' duration. Petitioner presented with a history of chronic back and shoulder pain reporting that he was injured at work earlier in the year and had undergone x-rays at that time. Petitioner's doctor was out of town. He also reported being seen at DMH Express by another provider and being given a steroid pack and pain medication. The steroid pack had worked quite well. Today his back and shoulders were hurting more and his neck was really stiff. He reported having Flexeril at home but not taking it for quite a while. Petitioner recalled his current symptoms being similar to one he had in June when he injured his back. He noted no relief from Vicodin or NSAIDs. On examination Petitioner had decreased range of motion of his neck, shoulders, and back. He was unable to bend at the waist or twist without pain. His grips were equal and strong. He was diagnosed with shoulder pain and lumbar back pain and given updated prescriptions and a Medrol dose pack. Petitioner was advised to follow up with his doctor. Petitioner was given an off work slip for that day. (PX 5)

Petitioner returned to see Dr. Cavanagh on September 25, 2014 regarding right shoulder pain. Petitioner reported going to the emergency room while the doctor was on vacation but insurance messed up his account and he couldn't get his prescriptions filled. Petitioner was complaining of right medial scapular shoulder pain of about ten days' duration. Petitioner had "recollection of injuring it but has been doing some heavy lifting and pulling associated with his job." He could move it reasonably well but noted pain with extension of the shoulder. Petitioner's diagnosis was listed as thoracic back pain. He was given a Medrol dose pack and medication for weight loss which Petitioner had expressed interest in obtaining. (PX 3A)

On October 6, 2014 Petitioner's attorney sent Respondent's attorney the bill from Decatur Ambulance Service. (PX 8, p. 6)

When Dr. Cavanagh re-examined Petitioner on December 3, 2014 Petitioner continued to complain of ongoing back pain and a sharp, shooting, burning sensation in his low back that radiated down his leg when driving, sitting, walking, and lying in bed. Petitioner wanted a referral to a chiropractor. Dr. Cavanagh noted that Petitioner had injured his back while driving a fork lift truck in June of this year when he apparently "hit something lying on the ground and this caused the machine to jerk violently, which hurt his back. Initially the pain was in the thoracic and lumbar areas but now has localized to the lower lumbar area." Petitioner was advised to return as needed. (PX 3A)

On January 17, 2015 Petitioner underwent a lumbar spine MRI as ordered by Dr. Cavanagh. It

revealed no significant central canal or neural foraminal encroachment. At L5-S1 there was possibly a very small radial tear present. No significant associated central canal stenosis was noted. There was possibly some very mild right-sided neural foraminal encroachment. (PX 4B)

On July 14, 2015 Petitioner's attorney forwarded medical records and bills to Respondent's attorney regarding the June 4, 2014 accident. He further noted that Petitioner continued to have low back pain and burning in his hips but wasn't undergoing any treatment mainly because he couldn't confirm coverage/payment for his treatment. (PX 8, pp. 7-8)

Dr. Cavanagh's Deposition

The deposition of Dr. Cavanagh was taken on July 15, 2016. (PX 3D) Dr. Cavanagh is a family medicine physician who has treated Petitioner since November 18, 2013. Dr. Cavanagh testified consistently with his office notes. He further testified that Petitioner's presenting complaints on June 5, 2014 were new ones and he had never seen him on prior occasion for similar complaints. He felt Petitioner's symptoms on June 5, 2014 were consistent with the work injury that Petitioner had described to him. (PX 3D, pp. 7-9, 19) The doctor testified that he felt Petitioner had sustained a mild concussion and fairly acute back strain. (PX 3D, p. 9)

Dr. Cavanagh testified regarding his examinations of June 9, June 16, June 19, 2014 consistent with his office notes.

Dr. Cavanagh testified that he did not feel Petitioner was exaggerating or magnifying his symptoms. He explained that it is quite common with a back strain for the pain to get worse for a few days after the accident due to increased inflammation. (PX 3D, pp. 11-12, 15)

Dr. Cavanagh also testified that he issued a letter on June 16, 2014 trying to explain Petitioner's injuries and stating his opinion that the injuries were due to his work injury. (PX 3D, p. 14) He also wrote two letters on June 23, 2014 regarding Petitioner's injuries, one of which (PX 3D – dep. ex. 7) was not given to Petitioner. (PX 3D, p. 17)

Dr. Cavanagh testified that he did not recall Petitioner ever complaining of chronic low back pain prior to his accident. He did mention it, at times, however. (PX 3D, p, 19)

Dr. Cavanagh also testified that he last saw Petitioner in January of 2016 but it wasn't for any back complaints. He hasn't seen Petitioner for any back problems since September of 2014. (PX 3D, p. 21)

On cross-examination Dr. Cavanagh testified that the letter of June 23, 2014 that wasn't sent to Petitioner (dep. ex. 7) mentioned spasms on examination. The doctor explained that while his office note didn't mention spasms, the letter was drafted quite shortly after the exam and most of it came from memory. (PX 3D, p. 22) He further testified that the presence of spasms on the 23rd wasn't a new finding as it had been present since he first saw him after the accident. He referred to it as tenderness as he uses those terms interchangeably. (PX 3D, pp. 23-24)

Dr. Cavanagh was also asked if it would be unusual for a person with chronic back pain to exhibit spasm at times and he replied that the majority of the time there probably wouldn't be spasms

but it could occur with back pain reasonably frequently. (PX 3D, p. 24)

Dr. Cavanagh agreed that by the visit of June 16, 2014 Petitioner was no longer complaining about any concussion symptoms or neck, upper back, or arm symptoms/complaints. As a result, he would agree that those symptoms had resolved and Petitioner has never complained about them since. (PX 3D, pp. 24-25)

Dr. Cavanagh further testified that if the history provided to him by Petitioner was not correct his opinion on causation might change. (PX 3D, pp. 25-26)

Deposition of Dr. Fabrique

The deposition of Dr. Fabrique was taken on July 18, 2016. (RX 2) Dr. Fabrique specializes in Occupational Medicine and is employed by HSHS Medical Group in Decatur. Dr. Fabrique testified that HSHS has direct ownership of St. Mary's Hospital in Decatur. As part of his employment for HSHS Dr. Fabrique provides services for Respondent's Decatur facility including wellness exams, surveillance exams and testing, drug screening, and treatment of occupational injuries and illnesses. Dr. Fabrique testified that he is often called upon to express an opinion regarding medical causation of particular conditions or issues. (RX 2, pp. 1-8)

Dr. Fabrique testified that he first saw Petitioner, in regard to the alleged accident herein, on June 23, 2014. He had, however, prior to that time became aware of an incident Petitioner alleged occurred on June 4, 2014 and it was his understanding that Petitioner was operating a forklift and some material fell from it and disintegrated in some way (he believed it was a wooden pallet) after which Petitioner ran over the material and he struck his head on the top of the vehicle and then became sick to his stomach and had neck pain and some blurred vision. (RX 2, pp. 8-11)

Dr. Fabrique further testified that it is standard protocol for an individual to fill out and sign an incident report when they report an incident. Petitioner did so and, according to it, Petitioner was also complaining about his low back and hips. He was transported to the hospital per Dr. Fabrique's orders because Petitioner had possibly sustained a serious head trauma. After Petitioner was seen at the hospital he returned to the Medical Department and was examined by nurse Jerry Cunningham. Mr. Cunningham noted that Petitioner was acting relaxed, comfortable and did not appear to really be suffering any signs of an acute injury. Based upon that Dr. Fabrique felt Petitioner could resume normal activities. Dr. Fabrique further testified that the emergency room hadn't suggested anything else either. Dr. Fabrique told Petitioner to return the next day just to see if any additional symptoms had emerged. (RX 2, pp. 11 – 13)

Dr. Fabrique testified that he then reviewed what information was available to him from the sources that had reported the incident and he did not feel Petitioner's complaints lined up with what the doctor suspected had happened. He then received information from the safety department that had done an equipment examination and some testing regarding the forklift involved in the alleged accident. Dr. Fabrique testified that he felt it was a little unusual for an individual to wait forty minutes to tell someone he had had an incident when he was claiming he suffered a rather severe injury and was sick to his stomach and vomiting. He found no real proof that Petitioner had, in fact, vomited. According to Dr. Fabrique there was no location where evidence of that fact could be found. Additionally, the vehicle Petitioner was operating was examined and the seatbelts were functioning properly which made

him think it would be unusual to strike one's head if the belts were functioning normally and being used. Dr. Fabrique also understood that the forklift had an impact alarm that goes off when there is a significant impact and a sensor controls the alarm. The sensors, as Dr. Fabrique understood things, were fulling functioning in the vehicle. It was his understanding, however, that the sensors had not triggered. (RX 2, pp. 13-17)

Dr. Fabrique testified that he noted the foregoing concerns in Petitioner's chart. He then re-examined Petitioner on June 23, 2014 when Petitioner was trying to return to work after having been off work per his doctor, Dr. Cavanagh. At that time Petitioner was taking a muscle relaxant, two pain relievers, and an anxiety medication all of which would be considered sedatives and might result in difficulty in a factory work setting. Dr. Cavanaugh had issued restrictions which Dr. Fabrique agreed to abide by. Dr. Fabrique did not examine Petitioner on the 23rd. (RX 2, pp. 17-19)

Dr. Fabrique saw Petitioner again on July 3, 2014 at which time Petitioner reported residual low back pain at a level of "4/10" but he felt he was able to perform all of the requirements of his current job. Dr. Fabrique examined him at that time and found his back motion, forward flexion very rapid and complete and his gait to be normal. He saw no evidence of any neuropathy. He was given restrictions of no working second shift or night shift but that was due to something unrelated to the alleged June 4, 2014 event. Dr. Fabrique did not see Petitioner again after that. (RX 2, pp. 19-20)

Based upon all of the information and history provided to Dr. Fabrique regarding Petitioner's case it was his opinion that the events of June 4, 2014 were unrelated to Petitioner's symptoms. (RX 2, p. 21)

On cross-examination Dr. Fabrique acknowledged that "pretty much" all of his opinions are based upon information received from people working for Respondent. He also relied upon information from Wiese Company. Dr. Fabrique also testified that "If the incident happened, it was not the cause of the described complaints. I think I would put it that way. Whether the pallet disintegrated or fell off the forks of a fork lift truck or not, I don't know." (RX 2, p. 22) Dr. Fabrique also testified that what constitutes a "long delay" in reporting an incident depends upon the severity of the accident. He explained that in Petitioner's case, "there were a lot of symptoms presented," and when he was taken by ambulance the concern was over a possible head injury. Dr. Fabrique also testified that he was concerned that Petitioner had suffered a head injury based upon what people who had called the nursing staff and reported. Had there not been a 40 minute delay his opinion might change. He also testified that if there were evidence of emesis that could change his opinion. His concern about the seat belt was that it should not be broken loose, or be loose in anyway and that the "clicker portion" was properly clicking. Regarding the impact alarm, it was Dr. Fabrique's understanding that it is activated when there is significant forces involved in an event that the truck goes through. He did not know what amount of force was required to activate the alarm. He assumed it would have to be a fairly significant force or it would be going off all the time if there was a small bump. Dr. Fabrique acknowledged that he did not speak to the Wiese Company about the incident; rather, he was aware of a report generated by Respondent's safety department through the Wiese Company. (RX 2, pp. 22 – 26)

On further cross-examination Dr. Fabrique acknowledged that when he wrote his report on June 5, 2014 he had spoken to Respondent's medical staff and the safety department but he had not spoken with Petitioner. He further testified that he saw the imaging studies from St. Mary's and while he did

not recall the exact details of it he remembered that the imaging studies were not of any great importance as there were no great abnormalities noted. He also recalled that Petitioner received a shot of Toradol. Tramadol is an oral medication. When asked about the significance of being given a shot of Toradol in terms of Petitioner's level of pain, the doctor replied that he was uncertain of what Petitioner's level of pain was in the emergency room. However, as he has worked in an emergency room he knows that if patients complain of pain they are given injections. It probably would have been given after an examination. If there were objective findings of pain and believable reports of pain from the patient an injection would be given. (RX 2, pp. 26-29)

Dr. Fabrique agreed that nausea can be a symptom of head trauma. He also testified that when he examined Petitioner on June 23rd it occurred at Respondent's facility. At that time Petitioner was disqualified from returning to work per the safety department and not by him. Dr. Fabrique cleared him to return to work at that time. Dr. Fabrique agreed that the Xanax Petitioner was taking at that time would not have been for his back pain but the other medications would have been.

Dr. Fabrique was asked a hypothetical regarding the events of June 4, 2014 and whether those events, if true, could have caused Petitioner's complaints. The doctor replied in the affirmative. (RX 2, pp. 29-33)

On redirect examination Dr. Fabrique was shown the records from Petitioner's June 4th ER visit. After being shown the notes regarding the examination of Petitioner's back, he testified that they reflected his back was non-tender on exam and there were no positive findings regarding Petitioner's back noted at that time. (RX 2, pp. 33 -34)

On further cross-examination Dr. Fabrique acknowledged that he had not seen the ER notes when he made his opinion of June 5th. He also agreed that Petitioner received a shot of Toradol for pain while at the ER. The doctor went on to explain that in an emergency room setting patients with pain will get medication. He also testified that pain is subjective and many times there are no objective findings. Migraine headaches are illustrative. If someone goes into an emergency room complaining of a migraine he will receive a pain shot. Sometimes they are migraines; sometimes they aren't. He agreed that pain can be a symptom of an injury. (RX 2, pp. 35-36)

The Arbitration Hearing

Petitioner's case proceeded to arbitration on August 19, 2016. The disputed issues were accident, causal connection, temporary total disability benefits, medical expenses, nature and extent, and penalties and attorney's fees. The parties stipulated that Respondent received a copy of Petitioner's penalty petition on/about April 19, 2016. They also stipulated that Respondent could receive a general credit for any medical bills paid by its group medical plan as opposed to the sum certain stated on the Request for Hearing form. (AX 1) Several witnesses testified including Petitioner, Dan Daugherty, and Benjamin Davis.

Petitioner testified that he had worked as a forklift truck operator for several years for Respondent. He also testified that prior to that he had worked in the Decatur area as a welder and fabricator.

Petitioner testified that he reported for work on June 4, 2014 with no disability or symptoms.

Petitioner testified that he did his safety check on the forklift truck and it was running fine. He testified that the key fob on the truck didn't actually work. He didn't know about the impact sensor. The fork lift truck contained a seatbelt for the operator's use and a roll bar roof which partially enclosed the operator for his safety. Petitioner described as he sat in the fork lift truck the roll bar/roof was only inches above his head. The fork lift truck also contained a collision sensor to detect front or rear collisions with an alarm which would activate if a collision occurred.

Petitioner further testified that on June 4, 2014, he had only had water and other liquids for breakfast and soon after commencing his shift he was involved in moving three pallets with his fork lift truck. According to Petitioner, the pallets are large wooden frames (estimated at 6 x 6) designed as a platform for heavy machinery parts; each pallet had six wooden blocks nailed to the underside to allow the fork lift truck driver to lift and move the pallets. Three pallets were on Petitioner's fork lift truck as he drove to a collecting station (dunich yard) on Respondent's premises.

Petitioner testified that his route with the fork lift truck and pallets necessitated crossing railroad tracks which rose 3-4 inches above the path surface. Petitioner described the tracks as very rough. Petitioner slowed as he approached the tracks, and while crossing the tracks with the resulting bounce, some of the blocks on the pallets fell from the forklift load into the fork lift truck path. Petitioner drove over one or more of the blocks causing a huge bounce for the fork lift truck causing Petitioner's body to be thrown up and above as he sat in the operator's seat. Petitioner struck an unprotected portion of his head on the roll bar/roof and his body twisted and struck parts of the fork lift truck.

Petitioner further testified that he was wearing a seatbelt at the time of this incident but described that material, placed by Respondent to assist identifying seatbelt use, had bunched-up causing slack in the seatbelt so that the seatbelt was loose as he operated the fork lift truck. Petitioner explained that when he first started out that day the seatbelt was tight but after turning around getting in and out of the fork lift truck the safety cover was loose.

Petitioner testified that he slammed on the brakes and immediately stopped the fork lift truck and sat dazed in the fork lift truck for 3-4 minutes as the result of the head trauma he sustained. Afterward, he shut off the fork lift truck, exited it and placed two of the wooden blocks which had fallen from the pallets into the operator's area of the fork lift truck and then proceeded with his pallet load to the collection area. Petitioner testified that while doing so, he was experiencing head pain and a nauseous feeling. Petitioner also testified that when he raised up the forks on the truck to continue driving he noticed the bottom of the pallet had fallen off.

After depositing the pallets, Petitioner immediately drove his fork lift truck to his work area where his supervisor, Dan Daugherty was present. He believed it took about five minutes. Petitioner testified that he advised Mr. Daugherty of the fork lift truck incident, that he his head hurt, and that he felt nauseous. Petitioner testified that he requested permission to go to Respondent's medical department but Mr. Daugherty told Petitioner to sit down at the break table as he had to call the safety department and notify the medical department. Petitioner testified that he waited but that he also went into the bathroom where he vomited. Petitioner returned to the area, told Mr. Daugherty he was not feeling good and that he needed to go to medical. Petitioner also testified that Mr. Daugherty told him to sit down at which point Petitioner told Mr. Daugherty he wasn't going to wait for safety to come down; rather, he was proceeding to the medical department. According to Petitioner, Mr. Daugherty

told him to sit at his desk and Petitioner then vomited again. Petitioner testified that he started to clean up the area but was stopped by Mr. Daugherty and send to medical. Petitioner testified that as he walked to the medical department he noticed back and hip pain.

Petitioner testified that when he arrived at the medical department he reported his head trauma, nausea, and other symptoms. He was transported by ambulance to St. Mary's. Petitioner testified that at the hospital he was given an injection and underwent x-rays. He further testified that, upon discharge, Mr. Daugherty picked him up and they returned to Respondent's facility. Petitioner testified that he didn't finish his shift as he was feeling a "burning sensation." He then called his personal doctor, Dr. Cavanagh and an appointment was scheduled for the next day. Petitioner testified that the shot he was given at the hospital didn't help with the burning sensation or his hip.

Petitioner testified that Dr. Cavanagh took him off work but released him to return to work on June 23, 2014; however, he was released with restrictions which Respondent wouldn't accommodate. He eventually returned to work on July 7, 2014.

Petitioner testified that he returned to work driving a fork lift truck. He explained that he was happy to return to work but when he did so his desk was gone. His hip still hurt and he had a burning sensation; however, his head was fine when he returned to work. Petitioner testified that he cannot do as much as he used to do. He goes walking with his wife and kids and he has to take more breaks because it feels like there is a burning sensation in his hip. He cannot do as much as he used to be able to do and cannot lift like he once did. He "pretty much" has to watch what he is doing so it doesn't flare up. If it does, he spends the rest of the night miserable. He was laid off from Respondent as of January 2, 2015.

Petitioner testified that there were cameras in the area where the accident occurred because every building in the plant has a camera.

Petitioner testified that the ambulance bill and ER bill remain unpaid.

On cross-examination Petitioner testified that after being laid off he initially stayed at home parenting and "finished up" a food truck business he had operated. Petitioner, at the time of arbitration, was working in Decatur as a welder. That job requires him to pull a welding cart weighing about 150 lbs. and to go up and down ladders. Petitioner testified to some trouble with ladder climbing. He further testified that the last time he saw Dr. Cavanagh was in September of 2014 explaining that he didn't have insurance once he was laid off so he couldn't go to a doctor. Petitioner now has insurance.

Petitioner estimated that he was driving the fork lift truck 5-6 mph and slowed down to 3-4 mph on the tracks. He wasn't sure how many blocks he ran over. He recalled that a third block was found under the fork lift truck but he originally only knew about the two lying on the ground.

Petitioner could not recall if he lost consciousness but he was "dazed."

Petitioner also testified to having a conversation with Mr. Daugherty when he returned to work in July. There might have been another person present but he wasn't sure. Petitioner testified he spoke to Mr. Daugherty about wanting to file a grievance over an interaction with the male nurse in the medical department who had made Petitioner feel like a criminal. Petitioner denied that he called the

male nurse an inappropriate term but he acknowledged being suspended the next day for his behavior.

Dan Daugherty testified for Respondent that he was a section manager for fabrication on June 4, 2014, and was Petitioner's supervisor. He testified that he was at his desk by the break area on that date when Petitioner came to him and said that he had bumped his head and was nauseous. Mr. Daugherty asked him what had happened and he said that he bumped his head in the fork lift truck. He did not show any outward sign of distress, such as clutching his head. He did not vomit in front of Mr. Daugherty, have any dry heaves, or tell him that he had gone to the bathroom and vomited. After Petitioner's return to work on July 7, he had a conversation with Petitioner and Jennifer Kearney, the union steward. Petitioner asked him if he had seen him vomit and Mr. Daugherty replied that he had not. Petitioner then became upset and called him a liar.

After the report of injury on June 4, 2014, Mr. Daugherty asked him a basic few questions and then sent him to medical to get checked out. Thereafter, Mr. Daugherty participated in an inspection of the vehicle that took place in the staging area right next to his desk. After Petitioner was sent to medical, he called the Wiese technicians who service the lifts and started a visual inspection of the forklift. Mr. Daugherty was present for this inspection. He did not see any visible damage to the forklift. He observed the condition of the seatbelt and it was apparently in normal condition, as were the latches that operate the seatbelt. He went to the area where the incident was supposed to have occurred within the hour. He did not see anything lying around on the floor. He confirmed that there was a railroad track in that area which had not been used in quite some time. This had been built up to where it was not as bumpy as what it might have been when it was in use. The railroad has raised tracks, but not very much, no more than half an inch. Petitioner claimed that at one time, the tracks were raised two to three inches, but that there had been repair of the tracks within the past year to reduce that level. Neither Mr. Daugherty nor Benjamin Davis, the witness for Wiese, was aware of any repairs being conducted to the tracks. Mr. Daugherty confirmed that when the truck was inspected, there was a block in the cab of the truck. He found the block in the cab of the truck and it was the type of block that would have been affixed to the bottom of a pallet. Petitioner told him that it had fallen off. There was no video of this incident that Mr. Daugherty was aware of. If there was video he never heard anything about it. The block in question was a 4x4 block. It was angled at the ends and approximately 10 to 12 inches long.

Respondent called Benjamin Davis to testify. He is employed by the Wiese Company as a safety coordinator who works with fleet management systems, including keypads and sensors on the forklifts at the Respondent's Decatur plant. He has been doing this for seven years and eight months. He has a seat or desk at Respondent's facility and a maintenance bay for the forklifts. He is responsible for the impact sensors and keypads and has received training in this from the manufacturer's information; from his predecessor in his job; and from the manufacturer of the keypads and sensors.

Mr. Davis testified that on June 4, 2014, he had occasion to examine the electronics on the forklift in question. Mr. Daugherty testified that the forklift Petitioner drove up to his desk on June 4, 2014, was VD708 and a photograph of this was taken. (RX 4) Mr. Davis testified that this was the same forklift upon which he performed his checks. The sensor could only be checked after he entered into the system on the forklift via the keypad and the keypad was in working operation. He then checked the impact sensor to verify that it was functioning and it was. If an impact sensor on a forklift is not working, it sends an alert to the server which is his database for access and also sends him an

alert e-mail. He received no alert e-mail indicating a malfunction with the system or a failure of the sensor to function. He went back through the computerized records of this system between June 2 and June 5 and verified that there were no impact alarms or triggers on that forklift during that time period.

Mr. Davis further testified that the impact sensors are designed to register lateral forces, either side to side or front to back. They are mounted in the center of the vehicle closest to the center of gravity. They will trigger based on sudden decelerations. Mr. Davis indicated that he had spoken with Petitioner about the incident but he did not recall telling Petitioner that that specific vehicle had malfunctions or that the sensors were not working properly.

In rebuttal, Petitioner testified that the train tracks had been raised two or three inches and then concrete was poured to reduce that to half an inch.

The Arbitrator concludes:

ISSUE (A) WHETHER PETITIONER SUSTAINED AN ACCIDENT ON June 4, 2014 THAT AROSE OUT OF AND IN THE COURSE OF HIS EMPLOYMENT WITH RESPONDENT?

Petitioner sustained an accident on June 4, 2014 that arose out of and in the course of his employment with Respondent.

Petitioner was a fairly credible witness albeit somewhat inclined to exaggeration and/or drama. His testimony regarding the accident was corroborated by the histories he provided to various medical providers. While Petitioner testified that the key fob in the forklift truck wasn't working, Mr. Davis didn't rebut that testimony. He was never asked about a key fob; rather, he was asked about a key pad. Whether these are one and the same wasn't addressed. While Petitioner and Mr. Daugherty had very different recollections of the events pre-dating Petitioner being sent to the medical department, the Arbitrator believes Petitioner's head hurt and he felt nauseous. Mr. Daugherty didn't disagree with those complaints being reported. The Arbitrator finds it difficult to believe Petitioner would have made up such a story and symptoms when he was seeking emergency care for a head injury as that kind of information would be important to a medical provider. There appeared to be some undercurrent of tension between the parties throughout the hearing and references to employment issues and grievances were riddled throughout the exhibits and the hearing. For example, Petitioner's attorney noted in one of his letters that Petitioner was unaware he was under a "disciplinary watch" at the time of the alleged accident. Also, Dr. Fabrique testified to returning Petitioner to work in July of 2014 with restrictions which were unrelated to this accident but stemmed from something that had been going on for much longer than the current incident.

Furthermore, Respondent suggested no reason for Petitioner to fabricate an alleged accident and, in the end, the Arbitrator finds his testimony plausible.

Petitioner consistently described the details of the accident to his supervisor, the medical department, the ambulance personnel, emergency room personnel, and his family physician. The log for the fork lift truck corroborates Petitioner's testimony about performing the safety check list and the machine being turned on and off several times during the pertinent time period in question. Petitioner logged off at 8:42 a.m. He headed for Respondent's medical department by 9:00 a.m. At the medical

department Petitioner identified possible witnesses. Respondent produced no evidence that it attempted to locate those witnesses and speak with them. Petitioner testified, without rebuttal, that there are cameras throughout Respondent's facility and that the safety department conducted an investigation. However, no one from the safety department testified about the investigation it conducted. Mr. Daugherty testified that any video of the accident would have been a matter for the safety department.

Respondent contends that the accident could not have occurred as Petitioner alleges based upon Dr. Fabrique's determination of June 5, 2013 [sic] (RX 1, p. "9") Dr. Fabrique testified that if the assumptions he relied upon were incorrect the accident could have occurred. He also acknowledged that he did not speak with Petitioner regarding the accident. Thus, his opinion was only based upon information given to him by Respondent with no input from Petitioner.

Respondent presented no direct evidence to dispute Petitioner's accident. Respondent has denied accident based on circumstantial evidence, including Petitioner's delayed reporting of the accident. It is unclear how a forty minute delay in the reporting of the accident was determined; however, the fork lift log and medical department time entries don't suggest a delay in reporting the injury. Indeed, Petitioner testified, without rebuttal, that he returned to Mr. Daugherty promptly after the accident and reported it. The delay, if anything, may have been in allowing Petitioner permission to go to medical. Mr. Daugherty and Petitioner may have a disagreement over whether or not Petitioner vomited or how many times, but they agreed he reported feeling nauseous. Petitioner also testified that he vomited in the restroom. Petitioner also reported nausea to Respondent's medical department and the St. Mary's Hospital emergency department on the day of accident. Both Doctors Cavanagh and Fabrique testified that nausea is a sign of head trauma which would corroborate Petitioner's testimony that he hit his head on the top of the fork lift truck.

Respondent also claims that Petitioner's fork lift truck, including the collision sensor, was in good operating condition on the date of accident and that the sensor did not record any traumatic event as described by Petitioner. However, Benjamin Davis, an employee of Wiese Company stationed at Respondent's plant to service and maintain fork lift trucks, and a witness for Respondent, testified that the collision sensors are designed to detect collision or traumatic events only in a "horizontal" plane, such as a front or rear end collision, and that sensors do not detect traumatic events in a "vertical" plane which would be the type of event involved in the instant claim (the bouncing of the fork lift truck and driving over a heavy wooden block).

Mr. Daugherty also testified that he oversaw the inspection of Petitioner's fork lift truck after the alleged accident and found two pallet wooden blocks in the fork lift truck operator area just as Petitioner had described placing in the fork lift truck following the accident.

ISSUE (F) WHETHER PETITIONER'S CURRENT CONDITION OF ILL-BEING IS CAUSALLY RELATED TO THE INJURY?

Petitioner failed to prove that his current condition of ill-being in his low back and hip region is causally related to the accident of June 4, 2014.

While the Arbitrator does find that Petitioner injured his head, neck, right shoulder, and lower back/hips in the accident of June 4, 2014 she further finds that Petitioner reached maximum medical

improvement for those injuries as of August 13, 2014 when he was examined by Dr. Cavanagh. While Respondent may take issue with whether or not Petitioner sustained any low back/hip injury at the time of the accident Petitioner did complete a pain drawing on June 4, 2014 indicating injury to that part of his body. Whether nurse Cunningham was aware of that during their interaction was not addressed. When sent to the medical department, the Pass also states "bumped head and...." suggesting Petitioner might have been reporting additional injuries but, for whatever reason, they weren't stated on the Pass. Petitioner also consistently reported his complaints to ER personnel. While his back was noted to be non-tender in the ER records, no reference was made to his hips, Petitioner later alluded that he was not really examined below his neck, and he had been given a shot of Toradol. Again, the pain drawing of the same day, and found in Respondent's records, suggests low back/hip complaints.

Petitioner was diagnosed with a concussion and an acute low back strain. Dr. Cavanagh testified that as of June 16, 2014 Petitioner's head, upper back, neck and shoulders and arms were no longer symptomatic. Petitioner testified that his head is "fine" with no residual problems. While Dr. Cavanagh testified that he also treated Petitioner for low back and hip complaints which he related to the accident he also testified that he hadn't seen Petitioner for any back complaints since September of 2014. The Arbitrator notes that when Petitioner was examined by Dr. Cavanagh on September 25, 2014 it was solely for right shoulder pain of about ten days' duration. He had no specific low back or hip complaints at that time. The absence of any specific back or hip complaints at that time suggests that Dr. Cavanagh was incorrect in testifying that he saw Petitioner at that time for back problems. The Arbitrator also notes that Petitioner went to DMH Express Care North on September 10, 2014 for back, neck and shoulder pain of four days' duration. He did not see Dr. Cavanagh at that time nor does it appear Dr. Cavanagh was ever made aware of that visit. The history provided by Petitioner at that time isn't altogether clear as it suggests Petitioner may have been to another Express facility at some point in time but there are no records in evidence. In any event, Petitioner mentioned his work accident for Respondent but this particular episode was, by history, related to something that had occurred four days earlier and not the work accident. Prior to that time Petitioner had not been seen by Dr. Cavanagh since August 13, 2014. His chief complaint at that visit was chronic lumbar back pain which the doctor noted had been going on "for several years now" but which had been recently aggravated by a work accident. Petitioner had no radiating leg complaints at that time. He was working normally with moderate tenderness noted over his low back and told to use Ibuprofen or Naproxen as needed. No follow-up visit for six months was required. Based upon that visit, coupled with the onset of new pain on/about September 6, 2014, the absence of any back complaints when seen by Dr. Cavanagh on September 25, 2014 and Dr. Cavanagh's testimony that he hadn't seen Petitioner for any low back/hip problems after September 25, 2014 the Arbitrator finds that Petitioner sustained an aggravation of a pre-existing chronic low back problem that resolved on/before August 13, 2014. Petitioner failed to prove any treatment for low back/hip complaints thereafter was causally related to his accident of June 4, 2014. This is based upon the testimony of Dr. Cavanagh. While Petitioner did present to Dr. Cavanagh on December 3, 2014 with complaints of low back pain radiating down his leg and he underwent a lumbar spine MRI on January 17, 2015 Dr. Cavanagh (who was deposed in 2016) did not causally relate those visits or treatment to the accident herein.

Doctor Fabrique testified that his opinions on accident and causation were based on information provided to him by Respondent. Doctor Fabrique did not see or examine Petitioner until June 23, 2014, nineteen days after the accident, and his opinion on accident and causation were based on the information provided to him by Respondent. Doctor Fabrique was notified of Petitioner's injuries, including head trauma and nausea, on the date of accident and he directed Respondent to transport

Petitioner to the hospital; Respondent did not at that time indicate Petitioner's report of symptoms was unsubstantiated or untrue. Doctor Fabrique testified that nausea could be a sign of head trauma (Respondent's Exhibit 2 - Dr. Fabrique dep, p. 29). Doctor Fabrique testified that if Petitioner's described accident occurred that all of his symptoms would be causally related to the accident (Respondent's Exhibit 2 - Dr. Fabrique dep, pp. 32-33). However, the Arbitrator does note that the hypothetical posed to Dr. Fabrique was based, in part, on the absence of any prior head, neck, mid back, low back, and/or hip complaints and/or treatment. Petitioner had prior cervical complaints and treatment of some kind as he underwent a cervical MRI in May of 2011 (the radiologist noted it in the June 4, 2014 MRI report). Dr. Cavanagh testified that he had only been treating Petitioner since November of 2013. While he testified that prior to June 5, 2014 he had never seen Petitioner for similar complaints he also noted in his August 13, 2014 office note that Petitioner had been experiencing chronic lumbar back pain for several years which had been aggravated by his recent accident. Thus, records suggest some prior back issues and even Petitioner acknowledged at the ER that he had back pain over the years which would "come and go." (PX 2A)

In summary, Petitioner sustained a concussion, and neck, mid-back, and low back/hip strains as a result of his June 4, 2014 accident. Given Petitioner's own admissions in the ER records regarding prior low back pain complaints, the Arbitrator views the low back strain sustained herein as a temporary one which reached maximum medical improvement as of August 13, 2014.

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?

Petitioner claims medical bills totaling $12,338.13. They include charges to Dr. Cavanagh for services rendered on September 25, 2014 and December 3, 2014. Dr. Cavanagh testified that he did not treat Petitioner for any further back problems related to the accident herein after September of 2014. The Arbitrator notes that he examined Petitioner on September 25, 2014; however, that visit wasn't for Petitioner's low back or hips. Rather, it was for his right shoulder and unrelated to the claim herein. Thus, that office visit should not be awarded. Similarly, the services rendered on December 3, 2014 would be unrelated based upon the doctor's testimony. Therefore, Dr. Cavanagh's bill should be reduced by $196.00 leaving a net of $490.00. Additionally, Dr. Cavanagh did not causally relate the 2015 lumbar MRI to the accident herein. Therefore, the bill to Decatur Memorial Hospital for $3.431.30 is denied as is the bill to Decatur Radiology Service Corp. in the amount of $404.00. Consistent with her causation determination herein the Arbitrator declines to award the DMH Express Care North bill for $154.00.

In sum, Petitioner is awarded medical bills as found in PX 7 totaling $8,152.83. These include: Decatur Ambulance Service - $957.30; St. Mary's Hospital - $4,952.50; Infinity meds LLP - $582.00; Clinical Radiology - $254.50; KMP Service Corp. - $396.59; Dr. Patrick Cavanagh - $490.00; Decatur Memorial Hospital - $454.94; and Decatur Radiology Service Corp - $65.00. Respondent is entitled to a credit of $9,481.13 against total bills. BlueCross/ BlueShield will seek reimbursement for payment of work related treatment expenses, and Respondent is ordered to hold Petitioner harmless on any such reimbursement claim.

ISSUE (K) WHETHER TEMPORARY TOTAL DISABILITY BENEFITS ARE DUE TO PETITIONER?

Petitioner was temporarily and totally disabled from performing his full work duties for the period June 5, 2014 to July 7, 2014, and provided Respondent with off-work slips from Dr. Cavanagh confirming disability (PX 6). Dr. Cavanagh released Petitioner for work on June 23, 2014, with restrictions, but Respondent refused to allow Petitioner to return to work with the restrictions Dr. Cavanagh imposed. Dr. Fabrique confirmed that Dr. Cavanagh's work restrictions were reasonable (RX 2, p. 31). Respondent offered no evidence that Petitioner was able to work during this period.

Petitioner suffered a compensable work accident, his injuries and treatment are causally related to the accident, and he was temporarily and totally disabled for the period June 5, 2014 - July 7, 2014, a total of 4 6/7th weeks. TTD owed by Respondent is $1,933.77 (4 6/7th weeks at $398.13/week). Respondent is entitled to a credit for the group disability payments made to Petitioner as stipulated to by the parties.

ISSUE (L) WHAT IS THE NATURE AND EXTENT OF THE INJURY?

Pursuant to §8.1b (b) the Arbitrator bases the determination of permanent partial disability on the following factors:

i) No AMA rating was submitted by either party. Therefore, the Arbitrator gives no weight to this factor.

ii) The occupation of the injured employee. Petitioner was a fork lift truck operator for Respondent at the time of his accident. He returned to work in the same position. While he is no longer working for Respondent that is not on account of his injury herein. No evidence was presented proving or suggesting that Petitioner's lay-off was related to his accident herein. He has since gone on to find other employment as a welder and is working on a full-time basis. The Arbitrator gives weight to this factor.

iii) The age of employee at the time of the injury was 29. Given Petitioner's young age, the Arbitrator reasonably infers that Petitioner will have to live and work with the effects of his injury longer than a much older worker. The Arbitrator gives some weight to this factor.

iv) The employee's future earnings capacity is the same as it was prior to the injury. Petitioner stated that he had returned to work making the same rate of pay as prior to the injury. No other evidence as to impairment of future earnings capacity was submitted. The Arbitrator gives some weight to this factor.

v) Evidence of Disability as corroborated by the treating medical records. Petitioner was diagnosed with a concussion, neck, shoulder and arm pain, and an acute low back strain. Dr. Cavanagh's records and testimony indicate that Petitioner fully recovered from his head, neck, and upper extremity problems. Petitioner has had low back problems off and on prior to this accident. Dr. Cavanagh testified that he hasn't seen Petitioner for any further back problems since September of 2014. When last seen by Dr. Cavanagh

Petitioner was working normally and noticing pain when sitting. Range of motion of his spine was normal. Some moderate tenderness over his lower back and SI joints was noted as of August 13, 2014. Petitioner had no specific low back/hip complaints as of September 25, 2014. While Petitioner testified that he continues to suffer low back pain and reduced strength and stamina which adversely affect his ability to perform his work duties no expert opinion linking these ongoing residuals to his work accident herein was provided. While Petitioner may contend that he was laid off by Respondent and, therefore, had no health care coverage which would financially enable him to seek current treatment he could have proceeded with a 19(b) petition and hearing if he wished to have additional treatment authorized on his behalf. He did not do so.

Based upon the foregoing factors, the Arbitrator awards Petitioner 2.5 % loss of use of the body as a whole under §8(d)2.

ISSUE (M) WHETHER PENALTIES OR FEES SHOULD BE IMPOSED UPON RESPONDENT?

Penalties and attorney's fees are denied. The Arbitrator finds that Respondent's defenses were presented in good faith; that Respondent did not act unreasonably and vexatiously; and that compensation was not denied without good and just cause. Several witnesses testified at the arbitration hearing and presented issues which could only be addressed through a hearing. While Petitioner was not paid TTD benefits he did receive non-occupational disability benefits while off work. While medical bills were disputed, Petitioner's medical bills were paid and Respondent will hold Petitioner harmless for same. In the end, the issues in dispute required a hearing and presentation of evidence. While Respondent did not ultimately prevail on the liability issue, its position was taken in good faith.

****

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 up	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

TERRY DAY,

Petitioner,

vs. NO: 14 WC 14221

CITY OF SPRINGFIELD,
SPRINGFIELD POLICE DEPARTMENT,

17IWCC0503

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issue of permanent partial disability, and being advised of the facts and 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.

In his Decision, the Arbitrator applied the facts to Section 8.1(b) of the Act in arriving at 25% loss of use of the right leg. The Commission disagrees with the weight assigned by the Arbitrator to §8.1(b)(ii). The Commission hereby modifies the Arbitrator's Decision and finds that the Petitioner sustained 30% loss of use of the right leg. All else is affirmed and adopted.

The Arbitrator found Section 8.1(b)(ii) to be a mitigating factor relative to his permanent partial disability finding. The Arbitrator found that Petitioner returned to unrestricted employment as a patrolman on April 7, 2016. The Petitioner did not testify as to requesting or receiving any accommodation from his employer despite his job being quite physical. The Arbitrator further noted that while Petitioner described difficulties performing some aspects of his work duties, none of those activities prompted him to seek medical treatment. The Arbitrator also noted that Petitioner volunteered to work overtime on 40 occasions since his return to work.

The Commission finds that the facts as applied to Section 8.1(b)(ii) are an aggravating factor that support an increase in the permanent partial disability award. The Petitioner offered

specific testimony as to how his injury and the 5 resulting surgeries have impacted the ability to perform his job. Specifically, he experienced a very sharp pain on the inside of his knee during a foot pursuit; he experienced knee pain while attempting to sweep the leg of a suspect; he experiences increased knee pain while entering or exiting his patrol vehicle; he could not climb a fence while working; he has issues with stairs; and, he notices that his right knee is significantly weaker than left.

Because of his injury, Petitioner has experienced limitations that negatively impact the ability to perform his job duties. His occupation is physically demanding and no evidence was offered indicating that his condition will improve to the point where he no longer experiences pain while performing his job. While Petitioner has not sought medical treatment for his pain, the Commission believes that the lack of medical treatment since his return to work should not negatively impact the Petitioner, especially considering his desire to work full-duty despite ongoing pain.

Based on the above, it is the Commission's opinion that significant weight should be assigned to Section 8.1(b)(ii) resulting in an increase to 30% loss of use of the leg.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed February 6, 2017, is hereby modified as stated above, and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $721.66 per week for a period of 64.5 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused a 30% loss of use of the right leg.

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.

AUG 18 2017

DATED:

Michael J. Brennan

Thomas J. Tyrrell

Kevin W. Lamborn

MJB/tdm
D: 8/15/17
052

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

DAY, TERRY T
Employee/Petitioner

Case# **14WC014221**

CITY OF SPRINGFIELD/SPRINGFIELD POLICE DEPT
Employer/Respondent

17IWCC0503

On 2/6/2017, 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 0.62% 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:

1130 BUCKLIN LAW OFFICE
BRADFORD C BUCKLIN
984 CLOCK TOWER DR SUITE A
SPRINGFIELD, IL 62704

0332 LIVINGSTON MUELLER O'BRIEN
DENNIS S O'BRIEN
620 E EDWARDS ST
SPRINGFIELD, IL 62703

17IWCC0503

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
NATURE AND EXTENT ONLY

Terry T. Day
Employee/Petitioner

v.

City of Springfield/Springfield Police Department
Employer/Respondent

Case # **14** WC **14221**

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 **Edward Lee**, Arbitrator of the Commission, in the city of **Springfield**, on **December 28, 2016**. By stipulation, the parties agree:

On the date of accident, **January 7, 2014**, 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 **$73,733.40**, and the average weekly wage was **$1,417.95**.

At the time of injury, Petitioner was **41** years of age, ***married*** with **2** dependent children.

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

Respondent shall be given a credit of **$22,516.08** for TTD, **$10,848.49** for TPD, **$0.00** for maintenance, and **$0.00** for other benefits, for a total credit of **$33,364.57**.

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 $721.66/week for a further period of 53.75 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused **a 25% loss of use of the right leg**.

Respondent shall pay Petitioner compensation that has accrued from **January 7, 2014** through **December 28, 2016**, 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

2/6/17
Date

FEB 6 - 2017

In support of his findings in regards to Nature and Extent of Injury the Arbitrator finds the following:

Petitioner was injured on January 7, 2014 while performing his duties as a patrolman for Respondent's police department. Petitioner testified that in the early 1990s he underwent two or three surgeries to his right knee as a result of a work injury, but he did not file a workers' compensation claim as a result of that accident. No credit therefore exists which would affect the award in this case.

Following the January 7, 2014 accident Petitioner underwent five surgical procedures to the right knee:

1. 3/6/2014, by Dr. Ronald Romanelli, an arthroscopic posterior horn meniscectomy and debridement of a mild tearing of the ACL.
2. 11/13/2014 by Dr. Nathan Mall, a medial meniscus transplant and medial femoral condyle chondroplasty.
3. 11/27/2014 by Dr. Nathan Mall, arthroscopic synovectomy, anterior horn meniscus repair and irrigation and debridement for infection.
4. 3/10/2015 by Dr. Nathan Mall, arthroscopic partial medial and lateral meniscectomy, lysis for adhesions, debridement of scar tissue and manipulation under anesthesia.
5. 9/24/2015 by Dr. Nathan Mall, arthroscopic lysis of adhesions/scar tissue, partial medial meniscectomy, scar tissue debridement, chondroplasty of medial femoral condyle and medial tibial plateau. (PX #1 and #2)

Petitioner testified that following this accident he worked with no restrictions until he underwent the first surgery on March 6, 2014. Thereafter there were periods of time when he was totally disabled and periods of time when he was able to work with restrictions. He said Respondent accommodated the restrictions which were placed on him by Dr. Romanelli and Dr. Mall. While on light duty he did work processing police reports and FOIA requests, as well as assisting at the police academy with construction work for obstacles for the canine unit. He noted there were periods of time he was totally disabled following surgeries. He testified Respondent paid him all temporary total and temporary partial benefits for the periods he was off work and working restricted duty.

Petitioner testified that following his final surgery he continued to have stiffness and pain as well as some instability and some weakness in his quad muscles, so he underwent twelve weeks of physical therapy. When he last saw Dr. Mall in January of 2016 Petitioner said that physician allowed him to jog up to a block and walk a mile as well as climb ladders or stairs up to 20 feet. He also restricted his kneeling and squatting. Those restrictions did not allow him to resume full duty work, he continued working light duty until examined at Respondent's request by Dr. Li on March 15, 2016.

Petitioner testified that he described his job requirements to Dr. Li, including being able to run for up to three to five minutes, jump and kneel, climb fences and physically fight with combative individuals. After examining him for approximately thirty minutes Dr. Li returned Petitioner to work without restrictions. Petitioner said he returned to work full duty on approximately April 7, 2016. Petitioner said that as a police officer he typically has to quickly walk or jog a couple of times per week. When he actually runs he said he has pain in the knee. Occasions when he has to run usually last three to five minutes, and he said he was slow and he had an exaggerated limp. He said he had to modify how he fought a subject to trip him with his left leg as opposed to his right leg as when he tried to do it with his right he felt pain. While kneeling on that individual's back after taking him down he said he felt and heard a clicking in his knee and he filled out a first notification of potential injury report. He said jogging and getting in and out of a car at times also aggravates the clicking and causes pain. On a 0 to 10 pain scale he said his knee was normally a 2 or 3, not terrible.

Petitioner testified going up stairs was easier than going down stairs and that his right leg appeared to be weaker than his left, that when doing leg extension exercises he could lift 40 pounds with his left leg and only 10 pounds with his right. He said there was only a 10 pound difference between the legs when doing flexion exercises and leg curls. He noted that he could walk a mile to a mile and a half without huge problems.

Petitioner testified that the third surgery was to flush out an infection in the knee and the fourth and fifth surgeries were to trim out scar tissue which was restricting his range of motion. He said his motion was much better following those procedures. Petitioner said that following the fifth surgery he told Dr. Mall that he was excited as he was much better and was not having any popping in the knee and he had a good range of motion, and that continued to be true while he continued to be treated by Dr. Mall. He said when last seen by Dr. Mall on January 15, 2016 his knee was stable and he had good quad strength, at which time Dr. Mall said he was at maximum medical improvement. (PX #2)

In Dr. Li's report of March 15, 2016 he states that Petitioner advised him that he could walk fine, for a long time and that Petitioner told him he could not understand why he had an hour walking restriction or pushing/pulling and lifting restrictions. (RX #1) At arbitration Petitioner denied making these statements. Petitioner agreed that he advised Dr. Li that he typically did not have to kneel for a lengthy time and could self-limit his squatting. He also agreed that he told Dr. Li that walking fast did not cause him pain, but running did cause him pain.

Dr. Li in his report noted that Petitioner had a strong desire to return to his full duty work as a City patrolman, and Petitioner testified that was accurate. Petitioner also agreed with Dr. Li's reporting that the two of them discussed Dr. Li's allowing him to return to his previous position full duty and that if he could not do his former position, then a restriction on his running could be placed. (RX #1) Petitioner said Dr. Li told him he did not see any reason he could not return to full duty, Dr. Li wrote that if it turned out that he could not do his former job then a restriction on his running could be given, and Petitioner testified he had been told that by Dr. Li. (RX #1) Petitioner testified that he never subsequently asked Dr. Li for such a restriction on his running, nor did he contact him with any other complaint.

Petitioner returned to regular duty work in his previous position as a patrol officer on approximately April 7, 2016. He testified that since returning to full duty work he had made the same salary as he had prior to this accident plus any negotiated union raises. Petitioner acknowledged that in the eight and a half months since returning to full duty work he had volunteered to work overtime on 40 dates, many of those occasions being three and a half to four and a half hour periods of time covering half of another officer's shift. He said he did not take any sick days during that eight and a half months of full duty work.

Petitioner testified that he had not returned to see either Dr. Mall or his primary care physician, Dr. Bleyer, since returning to full duty work and had not received any treatment to his right knee in the eleven months before arbitration, last seeing Dr. Mall on January 15, 2016. He said he did not seek treatment after the incident he described where he swiped a man's legs out from underneath him or after those occasions when he ran and said he had difficulties.

Petitioner testified that as of the date of arbitration he had kept himself in reasonably good shape and considered himself to be in better shape and more capable than some of his fellow officers.

As this accident occurred after September 1, 2011, the Arbitrator notes that the Commission must base its Decision on the five enumerated factors set out in Section 8.1(b) of the Workers Compensation Act.

With regard to (i) of Section 8.1(b) of the Act, the reported level of impairment pursuant to the AMA Guidelines:

Dr. Li conducted a impairment rating pursuant to the AMA Guides to Evaluation of Permanent Impairment, Sixth Edition, as part of his examination of Petitioner. He noted that he used the meniscal allograft as a diagnosis and after applying modifiers for functional history, physical examination findings and clinical studies he determined Petitioner to have a diagnosis grade of B and a final lower extremity impairment of 6% yielding a whole person impairment of 2%. (RX #2) The Arbitrator gives this evidence significant weight.

With regard to (ii) of Section 8.1(b) of the Act, the occupation of the injured employee:

Petitioner resumed his unrestricted regular employment in his previous position as a patrolman with Respondent's police department on approximately April 7, 2016 and did not testify as to requesting or receiving any accommodations from his employer in the eight and a half months since returning to that unrestricted work. The Arbitrator notes that Petitioner's work can be quite physical on occasion, requiring him to run, jump, and have physical altercations with suspects. While Petitioner described difficulties he had experienced performing this work since his return to unrestricted duty, he also testified that none of the activities he had performed had prompted him to return to any physician to voice complaints or seek treatment or restrictions, further acknowledging that Dr. Li had offered to place such restrictions should he have difficulties. Petitioner also noted that he had volunteered to work up to four and a half hours of overtime on forty occasions in the eight and a half months since returning to full duty work. The Arbitrator finds this to be a mitigating factor in arriving at a finding of permanent disability.

With regard to (iii) of Section 8.1(b) of the Act, the age of the employee at the time of the injury:

The Petitioner was 41 years old at the time of injury. The Arbitrator notes that the Petitioner is neither young nor of advanced age and would appear to have numerous years of remaining work life. No evidence was introduced indicating that this condition would worsen with age or impede Petitioner's ability to perform his work or shorten or otherwise change his remaining work life. The Arbitrator finds this to be a neutral factor in arriving at a finding of permanent disability.

With regard to (iv) of Section 8.1(b) of the Act, the employee's future earning capacity:

The Arbitrator concludes Petitioner's earning capacity has not been permanently impacted by his injury as he testified that he was making the same wage at the time of arbitration as at the time of the accident plus any wage increases which had occurred in the interim, he had not missed any time from work on account of this injury since returning to duty work and had been capable and willing to work overtime on forty occasions in the eight month period prior to arbitration. The Arbitrator finds this to be a neutral factor in arriving at a finding of permanent disability.

With regard to (v) of Section 8.1(b) of the Act, evidence of disability corroborated by the treating medical records:

Petitioner suffered a torn meniscus as a result of this injury and subsequently had a meniscal allograft to replace the meniscus. After additional surgeries to alleviate an infection and free scar tissue he was able to return to his prior position as a patrol officer with no restrictions. He had worked without restrictions for over eight months as of the date of arbitration and had missed no work during that time due to the injuries incurred in this accident. Petitioner testified that when he actually runs he has pain in the right knee. He said when he does so he was slow and he had an exaggerated limp. He said he had to modify how he fought a subject to trip him with his left leg as opposed to his right leg as when he tried to do it with his right he felt pain, and that while kneeling on that individual's back after taking him down he said he felt and heard a clicking in his knee. He said jogging and getting in and out of a car at times also aggravates the clicking and causes pain. On a 0 to 10 pain scale he said his knee was normally a 2 or 3, which he said was not terrible. The medical records of Dr. Romanelli and Dr. Mall corroborate the treatment received through the date of his return to work without restrictions. No treating medical records were introduced for the period subsequent to his return to full duty work to corroborate his statements in regards to current complaints as he had not sought any treatment for his knee subsequent to his returning to full duty work. The Arbitrator finds the treatment prior to his return to full duty work to be an aggravating factor in arriving at a finding of permanent disability as there is corroborating evidence from treating physicians to support a finding of disability in that regard. The Arbitrator finds the post-return to work complaints to be a neutral factor in arriving at a finding of disability as there is no corroborating evidence from treating physicians to support those allegations of disability.

Based upon the above facts and findings the arbitrator finds that the accident of December 9, 2013 caused Petitioner to sustain a 25% loss of use of the right leg as provided in Section 8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Danny Thomas,

Petitioner,

vs. NO: 14WC 3152

Southeast Personnel Leasing, Inc.,

17IWCC0504

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed September 9, 2016 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 $29,100.00. 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 18 2017

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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

THOMAS, DANNY
Employee/Petitioner

Case# **14WC003152**

SOUTHEAST PERSONNEL LEASING INC
Employer/Respondent

17IWCC0504

On 9/20/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0355 WINTERS BREWSTER CROSBY ET AL
LINDA J CANTRELL
111 W MAIN PO BOX 700
MARION, IL 62959

5074 QUINTAIROS PRIETO WOOD & BOYER
LEO PLUCINSKY
233 S WACKER DR 70TH FL
CHICAGO, IL 60601

17IWCC0504

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Danny Thomas
Employee/Petitioner

v.

Southeast Personnel Leasing, Inc.
Employer/Respondent

Case # **14** WC **3152**

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 23, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **December 20, 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.

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

Per the stipulation of the parties, in the year preceding the injury, Petitioner earned **$28,080.00**; the average weekly wage was **$540.00**.

On the date of accident, Petitioner was **33** years of age, ***single*** with **0** dependent children.

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

ORDER

Respondent shall authorize the treatment recommended by Dr. Kube, including the dorsal spinal cord stimulator.

Respondent shall pay **the medical bills as set forth in Petitioner's Exhibits 1-11** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the provider(s). Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

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

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

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

Melinda M. Rowe Sullivan

Signature of Arbitrator

9/12/16

Date

ICArbDec19(b)

SEP 20 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(B)

Danny Thomas
Employee/Petitioner

Case # 14 WC 3152

v.

Consolidated cases: N/A

Southeast Personnel Leasing, Inc.
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is currently 36 years old and that in December of 2013 he worked for Respondent as a paramedic. He testified that on the date of accident, he was lifting a patient who weighed more than 1,000 pounds and had to assist him from the bed to the floor and move him out to the ambulance. He testified that he injured his lower back during the lifting process while bending and going through the doorway, and that he had an immediate pop, burning and pain, as well as numbness and tingling. He testified that he called work, reported the incident and thought it was a strain. He testified that he sought treatment the next day at the emergency room.

Petitioner testified that he went through physical therapy and various conservative treatment measures, including steroid injections which exacerbated the problem. He testified that he came under Dr. Kube's care, who has not recommended surgery other than a spinal cord stimulator. He testified that he had a trial cord stimulator in February of 2016, and that it improved the pain and went from a 7 or 8 of average daily pain down to a 4.

Petitioner testified that before the spinal cord stimulator, he had a lot of pain, burning, numbness and tingling in the lower lumbar area and down the buttocks and back and sides of his legs. He testified that he has not returned to work as a paramedic since the accident, and that he has performed some light duty jobs with the help of Respondent.

Petitioner testified that before the trial stimulator, the pain radiated around the saddle region down the back part of his legs into his buttocks. He testified that after the trial stimulator, his daily pain went to a 4. He testified that his pain has improved, but his other symptoms remain. He testified that Dr. Kube was recommending a permanent stimulator and that he wanted to proceed.

On cross examination, Petitioner testified that his employer told him to go to Ferrell Hospital on December 21st. He testified that he was referred to a physician's assistant at Ferrell Hospital Family Practice by the emergency room. He testified that Massac Memorial Hospital was the local hospital where he sought emergency services and that no one told him to go there. He testified that Harrisburg Medical Center was another local hospital where he was seen in the emergency room and that no one referred him there. He testified that he selected Dr. Kube and that he was not referred to him from someone else. He testified that Dr. Kube referred him to Dr. Trudeau. He testified that he answered the questions of Dr. Crane truthfully and agreed that he was examined by him. He testified that Dr. Hatchett may have told him that his urinary complaints were related to prostate problems. He testified that when

he went to the IME with Dr. Noren, his father went with him and that his father had a spinal cord stimulator.

On cross examination, Petitioner agreed that he completed questionnaires at every visit with Dr. Kube. He testified that he answered them truthfully. He testified that on February 11, 2016, he began working at Light the Way and that he has continued to work there since that date. He testified that he did not know his job title, but that while working there he did paperwork and drove people to doctor's visits.

On cross examination, Petitioner did not recall visiting a urologist prior to the accident but then admitted that he saw Dr. Kupper with the Urology Group in Paducah. He agreed that he believed he told Dr. Kupper that he was having difficulty voiding but was unable to recall the specifics of the visits. He testified that he did not get the normal urge to go to the restroom, which he understood was caused by his medications.

On redirect examination, Petitioner testified that he knew Dr. Kupper worked at Massac Memorial and that he had an abnormal urge, so he visited him for that issue. He testified that the medication he was taking was Cymbalta for depression. He testified that to his knowledge, the testing was normal. He denied seeing anyone regarding a urinary retention issue.

On redirect examination, Petitioner testified that after the accident, the urinary retention started in January and was a gradual onset. He testified that mostly it was an issue of not having the normal urge for urination, and that he believed he had some pain in the bladder region. He testified that he did not recall speaking to Dr. Kube about the issue.

On redirect examination, Petitioner testified that he saw Dr. Crane twice and that he would not answer any questions about what treatment he would or would not recommend. He testified that Dr. Jones agreed with Dr. Kube that a spinal cord stimulator should be used.

On further cross examination, Petitioner testified that he was taking Cymbalta for depression and a thyroid pill. He testified that he did not recall when he was diagnosed with diabetes, but testified that he was currently taking medications for diabetes.

The medical bills of Ferrell Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 1. The medical bills of Saline Valley Diagnostic/Radiology were entered into evidence at the time of arbitration as Petitioner's Exhibit 2. The medical bills of Southern Illinois Urology were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. The medical bills of Harrisburg Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. The medical bills of Massac Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. The medical bills of Memorial Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The medical bills of Western Baptist Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 7. The medical bills of Radiology Group of Paducah were entered into evidence at the time of arbitration as Petitioner's Exhibit 8. The medical bills of Prairie Spine & Pain Institute were entered into evidence at the time of arbitration as Petitioner's Exhibit 9. The medical bills of Saline Valley Diagnostic/Radiology were entered into evidence at the time of arbitration as Petitioner's Exhibit 10. The medical bills of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 11.

The medical records of Ferrell Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 12. Petitioner was seen on December 21, 2013 with a chief complaint of low back pain, more to the left side. It was noted that the onset was the day before, and that Petitioner stated that he was lifting a patient and felt immediate pain. The records noted a history of chronic back pain with a new injury. The final diagnosis was that of a back strain. (PX12).

The office note for Ferrell Hospital Family Practice dated December 26, 2013 noted that Petitioner was presenting for follow-up for an emergency room visit after getting hurt at work on December 20th. It was noted that Petitioner worked for Miller EMS and stated that he was lifting a very large patient with several other people and that someone started to drop one side so everyone let go of his side except for one other person to help the others and that he felt a pop in his back and a burning pain. Petitioner stated that his pain was just as bad if not worse and that he was moving slower but rest did help and that it felt like there was a knot in his back. It was noted that there was no history of back surgery or pain in the past. The assessment was that of low back pain with left lower extremity radiation. An x-ray was ordered at that time. (PX12).

The interpretive report for x-rays of the lumbar spine performed on December 26, 2013 noted that the films were interpreted as revealing mild spondylosis with mild disc space narrowing at L4-5 and slight levoconvex lumbar rotosciolosis. (PX12).

The office note for Ferrell Hospital Family Practice dated January 8, 2014 noted that Petitioner was being seen to go over the MRI results. Petitioner stated his pain was not better and was pretty much constant. It was noted that there was no new weakness in the legs, and that he had numbness intermittently now bilaterally in his lower extremities that went through his buttocks and almost down the full length of his thighs. The assessment was that of a herniated lumbar disk. It was noted that Petitioner was to be referred to a neurosurgeon, and that Petitioner would be referred to Dr. Gruber as that was where he wanted to go. (PX12).

The office note for Ferrell Hospital Family Practice dated February 6, 2014 noted that Petitioner presented complaining of bilateral lower extremity swelling. It was noted that Petitioner had a Foley catheter in and had for the last two weeks since he was having trouble urinating ever since he injured his back about five weeks ago. It was noted that Petitioner stated that his urine output had been down the last 3 or 4 days but he was sick recently. It was noted that Petitioner was seeing his urologist, Dr. Hatchett, on February 18th, and that he was also going to be seeing a neurologist which his neurosurgeon was setting up and that he had a nerve conduction study scheduled for February 24th. The assessment was that of bilateral lower extremity edema. It was noted that the MRI was negative for cauda equina syndrome and showed a few mild bulging disks. Petitioner was placed on Lasix. (PX12).

The office note for Ferrell Hospital Family Practice dated February 15, 2014 noted that Petitioner presented to talk about his severe back pain and possibly getting referred to pain management. It was noted that Petitioner had a herniated disk in his lumbar spine and had seen a neurosurgeon who sent him to a neurologist because he said there was nothing surgical to be performed at that time. It was noted that the neurologist thought maybe he had some "stretched nerves" along with his herniated disk. It was noted that Petitioner's pain was not radiating down his legs anymore but that his low back was still "really bad." The assessment was that of herniated disk, and Petitioner was told that he did not need to be taking other people's Percocet. It was noted that an attempt would be made to get him into Southern Illinois Pain Management to see if they could do some injections of some sort until he saw the neurosurgeon again since he was not yet a candidate for surgery. (PX12).

The office note for Ferrell Hospital Family Practice dated February 27, 2014 noted that Petitioner presented for a refill on his pain medication for his herniated disc, and that he recently saw his urologist and had a Foley catheter removed. It was noted that Petitioner had a nerve conduction study already and was awaiting the results. It was noted that Petitioner's pain was still radiating down his left lower extremity. The assessment was that of herniated disc, and his medications were refilled. (PX12).

The office note for Ferrell Hospital Family Practice dated May 2, 2014 noted that Petitioner was being seen for a follow-up on his emergency room visit last night. It was noted that Petitioner stated that he was having urinary retention again and that his neurologist called this intermittent cauda equina

syndrome. It was noted that Petitioner had restarted his Flomax and called his urologist. It was noted that Petitioner's back pain had been "really bad" lately and that the pain was radiating down his left lower extremity from his low back. It was noted that there were some inconsistencies on the drug screen. The assessment was that of urinary retention and herniated disk. It was noted that Petitioner stated that his Percocet was stolen, and it was noted that the physician's assistant would not refill it anymore. (PX12).

The office note for Ferrell Hospital Family Practice dated May 15, 2014 noted that Petitioner stated that his urination had gotten better and that he took out his Foley because it was hurting. It was noted that Petitioner was not able to complete physical therapy because of it flaring up his pain and his anuria. It was noted that Petitioner's pain had been very severe since the physician's assistant refused to give him Percocet at the last visit. The assessment was that of herniated disc, L5-S1. (PX12).

The office note for Ferrell Hospital Family Practice dated August 26, 2014 noted that Petitioner presented for a one-month check-up and refill on his Percocet and Valium. It was noted that Petitioner had to self-catheterize a few times since the last time he was seen and that it got worse if he aggravated his back at all so he had tried to just not do much. The assessment was that of herniated lumbar disc and urinary retention. It was noted that Petitioner seemed to be doing better with his urinary retention and was not having to self-catheterize as many times. At the time of the September 23, 2014 visit, it was noted that Petitioner's back was about the same and that he had had to self-catheterize about four times per month if he overdid it. It was noted that Petitioner would like a refill of his Percocet for breakthrough pain. The assessment was that of herniated lower disc, and the Percocet was refilled. (PX12).

The office note for Ferrell Hospital Family Practice dated December 15, 2014 noted that Dr. Kube was setting up a functional capacity evaluation and that he was having another NCV the next day. It was noted that Petitioner still had urinary issues, and that he had to self-catheterize 6-10 times per month. It was noted that Petitioner wanted a referral to a different urologist, and that he would like to try Dr. Galati. The assessment was that of (1) lumbar disc herniation; (2) lower extremity paresthesias; (3) anxiety; (4) urinary retention. At the time of the January 13, 2015 visit, it was noted that Petitioner presented for a one-month follow up and to discuss his functional capacity test and neurology appointment. The assessment was that of lumbar disc herniation. It was noted that the FCE indicated that he was unable to ever work as an EMT. It was also noted that Dr. Trudeau thought Petitioner would be a good candidate for a spinal cord stimulator trial for his bladder because he believed the urinary issues were related to his back. (PX12).

The subjective component of the office note for Ferrell Hospital Family Practice dated February 13, 2015 was illegible. The assessment was that of lumbar disc herniation, and Petitioner's medications were refilled. At the time of the March 11, 2015 visit, it was noted that Petitioner was still awaiting approval for the nerve stimulator recommended by Dr. Kube. The remainder of the note was illegible. The assessment was that of lumbar disc herniation and medications were refilled. At the time of the April 10, 2015 visit, Petitioner presented for follow-up and medication refills. It was noted that Petitioner had not had to catheterize that month. The assessment was that of lumbar disc herniation. Medications were refilled at that time. (PX12).

The office note for Ferrell Hospital Family Practice dated May 8, 2015 noted that Petitioner presented for follow-up for his back pain and prescription medications. Most of the subjective component of the office note was illegible. (PX12).

The medical records of Southern Illinois Urology were entered into evidence at the time of arbitration as Petitioner's Exhibit 13. Petitioner was seen on February 18, 2014, at which time he stated that his urinary retention started on January 24, 2014 and that he hurt his back at work on December 20, 2013 and heard a pop and a burn down his back, buttocks and legs. It was noted that a voiding trial would be done. At the time of the March 18, 2014 visit, Petitioner reported difficulty urinating and

incomplete emptying but reported no pain during urination. It was noted that Petitioner reported back pain but no muscle aches, no muscle weakness, no muscle cramps, no arthralgias/joint pain, no swelling in the extremities and no difficulty walking. Petitioner was prescribed Flomax. (PX13).

Included within the records of Southern Illinois Urology was an interpretive report for a uroflow study performed on March 18, 2014, which was interpreted as revealing possible strain of the abdomen with his flow. It was noted that Petitioner was to be treated empirically with Flomax, and that Dr. Hatchett would need to do a urodynamic study if he needed to get more information about his act for urination to rule out abdominal straining. A cystoscopy report also dated March 18, 2014 noted a possible neurogenic bladder. At the time of the April 15, 2014 visit, Petitioner was seen in follow-up for prostate obstructive symptoms. It was noted that Petitioner's problem started after his back injury on December 20, 2013 and that he required a Foley catheter for a period of time. It was noted that Petitioner was back to voiding normally. It was noted that Petitioner might have had some bit of disc inflammation that led to his difficulty urinating or it could have been due to requiring narcotics which made the bladder lazy. (PX13).

The records of Southern Illinois Urology reflect that Petitioner was seen on May 15, 2014, at which time Petitioner reported nausea and constipation, difficulty urinating and hematuria but reported no pain during urination and no incontinence. It was noted that Petitioner also reported tingling in the left buttock and thigh from a pinched nerve. Petitioner was instructed on self-catheterization. At the time of the July 21, 2014 visit, it was noted that Petitioner had a "supposed" worker's compensation injury and they had been trying to figure out whether he truly had a neurogenic bladder. It was noted that the confusion in his history was that Petitioner could feel when his bladder was full and could urinate, but that with too much activity he said he had to catheterize himself. The assessment was that of retention of urine and benign prostatic hypertrophy with outflow obstruction. It was noted that Dr. Hatchett indicated that Petitioner had a completely normal sensation and normal findings on cystogram and that it did not correlate with a neurogenic bladder from a lower back injury, and that Petitioner had a uroflow that was consistent more with obstruction secondary to benign prostatic hypertrophy versus neurogenic. It was noted that Dr. Hatchett thought Petitioner should have a second opinion from another urologist, and that it was his "strong" opinion that Petitioner was exhibiting findings consistent with benign prostatic hypertrophy versus neurogenic bladder or back-related injury. (PX13).

The records of Southern Illinois Urology reflect that Petitioner was seen on January 26, 2015, at which time it was noted that Petitioner had been seen by a neurologist and that it was still not 100% clear whether his problems urinating were due to a radiculopathy or prostate issues or both. It was noted that Petitioner's medications had not been effective in changing his ability to void. It was noted that an in-office test for InterStim was offered, and that if the test did not show any improvement then it would be more indicative that it was due to nerve injury, but that even if it did show improvement it was still not clear if it was nerve injury as an etiology. It was noted that this was a complex case. At the time of the May 20, 2015 visit, it was noted that Petitioner's neurologist was concerned that the amount of pain medication Petitioner was taking was causing part of the problem and since he had decreased it had resolved. It was noted that Petitioner was having a nerve stimulator trial per Dr. Kube and if it worked he could decrease his pain medications and that should fix the urinary retention issue. (PX13).

The medical records of Harrisburg Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 14. Petitioner was seen on January 24, 2014, at which time he was seen for back pain from a worker's compensation claim. It was noted that Petitioner went to Massac Memorial earlier that day because he could not urinate, and that he was cathed and sent home. It was noted that Petitioner continued to be unable to urinate and had had a CT and an MRI that showed bulging and herniated discs. The interpretive report for a CT of the lumbar spine performed on that date was interpreted as revealing (1) no acute bony abnormality; (2) mild annular disc bulging L4-5 and L5-S1

without spinal stenosis or compression of neural structures; (3) mild degenerative bony changes. The diagnosis was that of urinary retention – unspecific; backache. (PX14).

The records of Harrisburg Medical Center reflect that Petitioner was seen on April 9, 2014 for lower back pain and it was noted that the pain radiated to the bilateral legs. It was noted that the onset was unknown, that the course had been waxing and waning and that the back pain had been occurring for four months. It was also noted that the mechanism of injury was that of heavy lifting on December 20, 2013. The diagnosis was that of low back pain and Petitioner was discharged home. At the time of the May 2, 2014 visit, it was noted that Petitioner had not voided since 18:00 the night before. Petitioner reported that he was unable to urinate, and the history of intermittent cauda equina syndrome was noted. Petitioner also complained of low back pain. The diagnosis was urinary retention – unspecific, and Petitioner was discharged home. (PX14).

The medical records of Massac Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 15. Petitioner was seen on December 27, 2013 for low back pain, and it was noted that he had starting after he lifted a heavy patient and had been to the emergency room earlier that day. It was noted that Petitioner had pain in the low back area and that it was radiating to the thigh, left more than right. The report for a CT of the lumbar spine performed on the same date referenced multilevel non-compressive annular disc bulge and facet arthropathy, and it was noted that the central canal and neural foramen were patent throughout. (PX15).

The records of Massac Memorial Hospital reflect that Petitioner was seen on April 9, 2014 in the emergency department for back pain. It was noted that Petitioner had an injury with back pain and had urinary retention and had cauda equina (not noted on exam) with a history of saddle anesthesia. The diagnoses were that of acute low back pain and chronic back pain. (PX15).

The medical records of Memorial Medical Center were entered into evidence at the time of arbitration as Petitioner's Exhibit 16. Petitioner was seen by Dr. Edward Trudeau on February 25, 2014 for an EMG and nerve conduction studies. The testing was interpreted as revealing (1) left S1 radiculopathy, moderately severe in electroneurophysiologic testing terms; (2) right S1 radiculopathy, mild in electroneurophysiologic testing terms; (3) no current evidence of L5 radiculopathy; (4) no current evidence of other radiculopathy; (5) no current evidence of entrapment neuropathy; (6) no current evidence of lumbar plexopathy; (7) no current evidence of mononeuritis multiplex. (PX16).

The records of Memorial Medical Center reflect that Petitioner underwent an EMG and nerve conduction studies with Dr. Trudeau on December 16, 2014. The testing was interpreted as revealing (1) bilateral S1 radiculopathies, moderately severe on the left side, mild on the right side, left greater than right in electroneurophysiologic testing terms, consistent with and similar to previous findings of February 5, 2014 [*sic*]; (2) no current evidence of other radiculopathy, particularly L3, L4 or L5; (3) no current evidence of entrapment neuropathy; (4) no current evidence of lumbar plexopathy; (5) no current evidence of mononeuritis multiplex. (PX16).

The medical records of Western Baptist Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 17. Petitioner was seen on January 25, 2014 for lumbar pack pain and inability to void. It was noted that it was described as moderate in degree and in the area of the left gluteus, lower lumbar spine and right gluteus. It was noted that the pain was still present and worsening, and that there was difficulty urinating and numbness to the groin that had started the day prior. It was noted that moderate sensory loss involving the right lower leg and upper leg and left lower leg and upper leg (saddle area). The clinical impression was that of acute pain in the lower back, probable herniated disc. It was noted that the clinical picture did not suggest spinal cord compression or abscess. An MRI of the lumbar spine performed on the same date was interpreted as revealing no acute abnormality and no

disc herniations; small annular tear centrally at L5-S1 with a small left paracentral disc protrusion; distal spinal cord appears unremarkable; no spinal canal stenosis is identified. (PX17).

The medical records of Prairie Spine & Pain Institute/Dr. Kube were entered into evidence at the time of arbitration as Petitioner's Exhibit 18. Petitioner was seen on May 21, 2014, at which time it was noted that Petitioner had been seeing a urologist. Dr. Kube noted that he did not see a neurocompressive lesion and that he recommended bilateral epidural steroid injections at L5-S1. Petitioner underwent (1) bilateral L5-S1 transforaminal lumbar epidural steroid injections and (2) epidurograph with radiographic interpretation on June 18, 2014 for a pre- and post-operative diagnosis of bilateral S1 radiculopathy. Petitioner was seen on July 2, 2014 at which time it was noted that he did not really see any substantial improvement in his condition with the epidural steroid injections. It was noted that Petitioner felt that the pain may have initially increased and that he had difficulty voiding. It was noted that Dr. Kube did not think it was necessarily a neurogenic issue causing his bladder retention. It was noted that Petitioner's examination and history had not been consistent with cauda equina, and that Dr. Kube thought Petitioner had a radiculopathy but that he did not see enough neurocompression to consider performing a decompression. Petitioner was recommended to undergo an FCE. (PX18).

The records of Dr. Kube reflect that Petitioner was seen on September 24, 2014, at which time it was noted that Petitioner was very concerned about the bladder issue and that the urologist felt that this could be associated with benign prostatic hypertrophy and did not feel it was spine-based. Dr. Kube noted that he would expect at least three roots to be involved to cause a bladder dysfunction, and that Petitioner's bladder dysfunction was not constant and only happened when he was doing a lift or a specific maneuver. It was noted that Petitioner did not present like cauda equina. A second opinion was recommended, and Dr. Kube considered the next step to be likely a long-term chronic pain management scenario. At the time of the December 3, 2014 visit, it was noted that Petitioner had undergone a second opinion and there were no additional ideas. It was noted that Petitioner wanted to move forward with a stimulator trial, and that an additional EMG was to be sought prior to proceeding. (PX18).

The records of Dr. Kube reflect that Petitioner was seen on January 14, 2015, at which time it was noted that the nerve conduction studies indicated chronic S1 radiculopathies, worse on the left than the right. It was noted that Dr. Kube believed that the S1 involvement along with some mild degree of benign prostatic hypertrophy was causing some of the urinary issue. It was noted that Petitioner had a functional evaluation, that he appeared to show a very nice effort, that he did not continue to qualify for his previous job and that Petitioner would be on a 40-pound permanent restriction. At the time of the May 20, 2015 visit, it was noted that Petitioner had sick sinus syndrome with respect to his heart, and that it had required him to have a monitor. It was noted that it was possible that he might need a pacemaker, which might change the long-term plan for him. It was noted that his permanent restrictions were the same (*i.e.*, per FCE). It was noted that Petitioner had come off of some of his pain medications, which seemed to have helped some of the bladder function issue. A stimulator trial was again recommended. (PX18).

The records of Dr. Kube reflect that Petitioner was seen on July 1, 2015, at which time it was noted that Dr. Kube had confirmed that it was okay for him to move forward with the stimulator trial even though he was using the LINQ system for his cardiac issues. A phone note dated December 11, 2015 noted that Petitioner called stating he believed that he would have a pacemaker put in and was wondering if it was still possible to have the spinal stimulator put in with a pacemaker. Petitioner was recommended to see Dr. Kube to discuss the issue. At the time of the January 6, 2016 visit, it was noted that Petitioner was doing basically about the same and seemed to be pretty motivated. It was noted that Petitioner had lost a significant amount of weight and that he had also weaned himself of almost all of his pain medications. It was noted that Petitioner was still having pain across the low back and down the posterior parts of both legs. It was noted that Dr. Kube thought Petitioner was a really good candidate for a dorsal stimulator trial to determine his candidacy for a permanent implant. It was noted that the LINQ pacer and

stimulator device systems were compatible. Petitioner underwent placement of a percutaneous spinal cord stimulator electrode array on February 1, 2016 for a pre- and post-operative diagnosis of chronic pain and radiculopathy due to trauma. (PX18).

The records of Dr. Kube reflect that Petitioner underwent x-rays of the lumbar spine on February 8, 2016, which were interpreted as revealing (1) no acute abnormality, compression fracture or subluxation; (3) interval placement of stimulator wire with tip terminating at T10-T11. At the time of the February 10, 2016 visit, it was noted that the stimulator trial was quite successful. It was noted that Dr. Kube wanted to set Petitioner up for a permanent paddle lead placement. At the time of the March 23, 2016 visit, it was noted that they had not moved forward with the permanent placement of the stimulator. (PX18).

The medical records of Lundberg Medical Imaging were entered into evidence at the time of arbitration as Petitioner's Exhibit 19. Petitioner underwent an MRI of the lumbar spine on January 7, 2014, which was interpreted as revealing approximately 6mm left paracentral disc herniation at L5-S1 without nerve root abutment or displacement and without spinal stenosis; degenerative disc disease at L3-4. (PX19).

The medical records of Orthopaedic Institute of Southern Illinois were entered into evidence at the time of arbitration as Petitioner's Exhibit 20. Petitioner was seen on October 16, 2014, at which time he was seen in consultation for low back pain with bilateral leg pain, burning and paresthesia to his knees. It was noted that Petitioner stated that his symptoms began on December 20, 2013 after lifting a patient at work, and that he had had one injection with Dr. Kube which made his symptoms worse. It was noted that Petitioner had 4 physical therapy visits and had to stop and that he had to get a Foley catheter. It was noted that Dr. Jones thought a spinal cord stimulator was a reasonable approach as Petitioner's symptoms were unlikely to respond to surgical intervention. (PX20).

The medical records of Joyner Therapy Services were entered into evidence at the time of arbitration as Petitioner's Exhibit 21. A Functional Capacity Evaluation was performed on December 22, 2014. It was noted that the results suggested that Petitioner put forth full and consistent effort during the evaluation, that he demonstrated the ability to perform within the light physical demand category and that his job as a paramedic was classified within the very heavy physical demand category. It was noted that Petitioner had inconsistencies with range of motion and biomechanical inconsistencies during floor to waist lifting and between bilateral and unilateral carrying. (PX21).

The transcript of the evidence deposition of Dr. Richard Kube was entered into evidence at the time of arbitration as Petitioner's Exhibit 22. Dr. Kube testified that he is board-certified by the American Board of Spine Surgery, the American Board of Orthopaedic Surgery and the American Board of Independent Medical Examiners. He testified that he first saw Petitioner on January 29, 2014, at which time he reported that on December 23, 2013 he was helping to lift a 1,000 pound man from his home while at work and that he felt a pop and burning immediately in his low back. He testified that it was noted that Petitioner indicated there was also numbness down the back of his buttocks, both sides, and in the backs of his thighs and hamstrings area, both sides. He testified that the Foley catheter was still present at the time of the visit. (PX22).

Dr. Kube testified that the MRI studies from January 5, 2014 and January 7, 2014 noted that Petitioner had a fairly normal appearance other than the L5-S1 region where there was an annular tear and mild to moderate disk degeneration. He testified that there was a small herniation that was maybe more left-sided than right but was fairly central. He testified that there was not a large canal-occupying lesion on the MRI. He testified that the physical examination revealed pain at both SI joints, left more than right; pain in the L4-5 region; significant sensory deficit in both lower extremities and buttocks; and positive straight leg raise at 20 degrees on both sides. He testified that with urinary retention and saddle

paresthesia, Petitioner had the appearance of a cauda equina syndrome, which was a surgical emergency. He testified that there was not, however, a disk herniation that he could remove, which was very uncharacteristic. He testified that saddle paresthesia typically was fairly suggestive of a multiple nerve involvement and was usually a result of some kind of a traumatic event such as a fracture or dislocation or a large disk herniation. (PX22).

Dr. Kube testified that it sounded like Petitioner immediately had symptoms consistent with cauda equina or impending cauda equina and that what he was describing was essentially a saddle paresthesia, but it did not seem like anyone "picked up on that" until such time that he had a urinary retention occur. He testified that the medical management was not within the standard of care. He testified that imaging should have been done immediately. (PX22).

Dr. Kube testified that Petitioner returned on May 21, 2014, at which point they were looking at doing epidural injections. He testified that Petitioner was regularly following with the urologist. He testified that the phone note 6 days after the injection noted that Petitioner reported an increase in pain after his injection, that there was tingling down his leg and that he had gone to the emergency department where an additional MRI was performed. He testified that Petitioner returned on July 2nd, at which time he reported no substantial improvement in his condition with the epidural injection and that it may have gotten worse. He testified that Petitioner reported difficulty voiding, and that his incontinence occurred when his pain was more severe. He testified that he did not believe that Petitioner was a surgical candidate, so an FCE was discussed. (PX22).

Dr. Kube testified that at the September 24th visit, Petitioner continued to have the same complaints and that he reviewed the MRI again, which showed a small protrusion on the left side of L5-S1 which was not directly compressing but could have been displacing slightly the S1 nerve root on that side. He testified that he thought it was reasonable for Petitioner to have another opinion if he desired because he was clearly concerned about the urinary retention issue. He testified that Petitioner returned on December 3, 2014, at which point they started talking about doing the stimulator trial. He testified that another EMG was ordered at that time, and that he wanted Petitioner to undergo an FCE. He testified that the 2nd EMG indicated chronic S1 radiculopathies, which were the two nerves that were problematic on the original study and now appeared to be chronic in nature. He testified that at that point, he felt like the nerve issues along with some mild degree of benign prostatic hypertrophy could be causing the urinary issues. He testified that the FCE was performed, and that Petitioner lifted 40 pounds and was a light physical demand level. (PX22).

Dr. Kube testified that, with respect to the utilization review letter that was issued on March 20, 2015, he did subscribe to the ODG and that his spine society did not recognize that as an authoritative text or guideline. He testified that spinal cord stimulation was used for a variety of intractable, chronic pain scenarios. He testified that his office typically appealed utilization reviews. (PX22).

Dr. Kube testified that he continued to monitor Petitioner for the remainder of 2015 and ultimately performed the placement of the trial dorsal column stimulator on February 3, 2016. He testified that the trial stimulator was successful, and that the conversion rate from a stimulator trial to an implant was typically 90+ %. He testified that the permanent placement had not yet been performed. He testified that the trial was done without authorization. He testified that the stimulator was going to help reduce Petitioner's opiate and anti-inflammatory usage as well. He agreed that his adoption of the FCE findings and whatever restrictions Petitioner had on the test were permanent in nature. (PX22).

Dr. Kube testified that he believed that Petitioner's current condition of ill-being was related to the accident that occurred in December of 2013. He testified that in the absence of anything previous of significance and an immediate onset, it was likely that the incident caused the problems that Petitioner was having. He testified that he believed that the trial dorsal stimulator was reasonable and necessary to

address the condition of ill-being in Petitioner's low back, and that he thought Petitioner was a good surgical candidate for the permanent placement of the stimulator. He testified that in the absence of the permanent stimulator, the other treatment plan would include medications and therapy. He testified that he anticipated that Petitioner's current physical restrictions would stay the same even after placement of the permanent stimulator. (PX22).

Dr. Kube testified that he believed that Petitioner's urinary retention was caused by his back injury or any resulting medication that he was prescribed following his accident. He testified that Petitioner's urinary retention was very profound and led to multiple emergency room visits over a very short course of time, and that it was a fairly alarming scenario that occurred after the saddle parethesia was going on. He testified that the recovery from the permanent stimulator surgery was typically about 3 months and that there was ongoing maintenance for the stimulator including battery replacement which would require an additional procedure. He testified that Petitioner may still require some medication, although hopefully significantly less. (PX22).

On cross examination, Dr. Kube agreed that he first saw Petitioner on January 29, 2014. He testified that Katherine Lutyens is his physician's assistant, and testified that she would have put together a lot of the notes. He testified that both he and his physician's assistant would have conducted a physical examination on that date. He agreed that the findings of L1 and sacroiliac joint point tenderness as well as L4-5 spinous process would be subjective findings. He agreed that pain was a subjective finding in that he was dependent upon Petitioner's report. He agreed that his physician's assistant indicated there was no evidence of cauda equina. He agreed that he testified that there were symptoms consistent with cauda equina, and that this included the urinary retention issue as well as the saddle paresthesia. He agreed that his diagnosis of cauda equina was at least in part based upon the report of urinary retention. (PX22).

On cross examination, Dr. Kube testified that he was not aware of any history of urinary retention issues that required Foley catheter placement or anything where Petitioner had a liter of urinary retention. He testified that it was his understanding that the urinary retention happened days before he was seen. He testified that Petitioner was having the pain and numbness into his buttocks and into the hamstrings, which was describing somewhat a saddle paresthesia at that time. He testified that that it was his understanding that Petitioner developed the urinary retention problem within a month of the accident. (PX22).

On cross examination, Dr. Kube testified that he would not be able to answer to any degree of medical certainty whether there would be any impact on his opinions if he were to find out that Petitioner had a history of prior urological problems and a recommendation for urodynamic testing as the question was vague. He testified that he was not aware of any specific prior urological problems or urodynamic testing recommended for Petitioner. (PX22).

On cross examination, Dr. Kube testified that on May 21, 2014, a physical examination was not conducted as Petitioner was there for a nerve study follow-up. He agreed that he rendered the diagnoses of muscle spasm, lumbar sprain/strain, lumbar degenerative disk, lumbar radiculopathy and lumbago, and that he recommended that Petitioner undergo epidural steroid injections. He testified that he was contemplating an injection and then re-evaluating to see whether or not Petitioner had improved. He agreed that he recommended injections only at the L5-S1 level and did not recommend any injections at the L4-5 level. He testified that the L5-S1 region was the most suspect, and that was where the disk herniation was located and also where the nerve study indicated neurologic issues were going on at both S1 nerve roots. He agreed that the epidural steroid injections were performed on June 18th. (PX22).

On cross examination, Dr. Kube agreed that he next saw Petitioner on July 2, 2014. He agreed that the ODI was based on Petitioner's completion of a questionnaire. He agreed that he noted that there

were not any neurocompressive lesions consistent with cauda equina. He testified that he did not believe that he ever reviewed the lumbar MRI dated June 23, 2014. He agreed that he recommended that Petitioner undergo an FCE as they had basically exhausted conservative non-operative maneuvers. He testified that Petitioner was basically approaching maximum medical improvement from a functional standpoint, and that the FCE was going to be something to help him determine what Petitioner could or could not do. He agreed that he did not recommend another epidural steroid injection because the first injection inflamed things and Petitioner ended up in the emergency room. (PX22).

On cross examination, Dr. Kube agreed that on July 18, 2014 Joyner Therapy called to say they attempted to schedule an FCE but Petitioner told him he did not want to undergo an FCE at that time. He agreed that on July 21st, his office called Petitioner regarding the FCE and he stated that he did not want to undergo the FCE. He agreed that on September 9, 2014, his office called Petitioner and he reported that he was going for a second opinion on October 16th and wanted to wait until after that to decide about going forward with the FCE. He testified that he did not know who Petitioner was scheduled to see on October 16th. He testified that it may have been Dr. Jones that Petitioner's counsel alluded to, but he did not have anything in his record telling him who exactly it would have been. (PX22).

On cross examination, Dr. Kube agreed that he next saw Petitioner on September 24, 2014, and testified that on that date he did not see saddle paresthesia. He denied knowing when Petitioner stopped showing saddle paresthesia. He testified that the MRI that he was referring to was the original MRI from Baptist Health on January 25, 2014. He denied recalling having talked to Petitioner's urologist or reviewing any of the urologist's records. He testified that he did not think that Petitioner had a frank cauda equina, but that it would be unusual for just a basic benign prostatic hypertrophy to cause bladder issues to that degree. He testified that on that date, it seemed like Petitioner's retention issues were more intermittent and some had improved, so he did not know that he would call it consistent with cauda equina at that point. He testified that the basis for recommending that Petitioner undergo an FCE was the entire constellation of issues going in, including the bladder retention, the occasional paresthesia and the pain that Petitioner reported he was having. He agreed that he recommended that Petitioner consider a dorsal column spinal stimulator or medication management. He agreed that this was the first time that he recommended that Petitioner consider a dorsal column spinal stimulator. He agreed that he wrote that he thought Petitioner was going to be relatively restricted based on the report of intermittent saddle paresthesia, the reports of intermittent urinary retention and the complaints of pain. (PX22).

On cross examination, Dr. Kube testified that he did not perform a physical examination on December 3rd, and that he noted that Petitioner had obtained a second opinion. He agreed that he again recommended an FCE as well as either medication management or a dorsal column spinal stimulator. He testified that Petitioner reported that he was still retaining urine at times, and that it was probably a combination of the nerve issues and the BPH. He denied that a physical examination was performed on January 14, 2015, and agreed that he released Petitioner to return to work within the restrictions as outlined in the FCE. He agreed that he indicated that Petitioner was on a 40-pound permanent restriction. He agreed that he continued to opine that SI involvement along with the mild degree of benign prostatic hypertrophy was causing Petitioner some urinary issues. He testified that he did not know if he had Petitioner's urology records for review and that they were basically going off what Petitioner reported. He testified that it was possible that Petitioner's urinary complaints were entirely related to benign prostatic hypertrophy, but that he did not believe that to a degree of medical and surgical certainty. (PX22).

On cross examination, Dr. Kube agreed that he was aware that Petitioner had diabetes. When asked if diabetes could be the sole cause of Petitioner's urinary complaints, Dr. Kube responded that it was pretty unlikely. He agreed that diabetes can cause pain in people who have peripheral neuropathy. He testified that diabetes could be a cause of neurogenic pain in cases of peripheral neuropathy, but

Petitioner never demonstrated anything like that on examination. He denied that diabetes can cause radiculopathy. (PX22).

On cross examination, Dr. Kube testified that he next saw Petitioner on May 20, 2015, at which time a physical examination was performed and no change was noted. He agreed that he did not note that Petitioner had saddle paresthesia on that date. He testified that on January 6, 2016, he did not examine Petitioner and that a discussion was had regarding the type of pacemaker that Petitioner was going to maybe require in the future would not have a problem with the type of battery to be used for the spinal stimulator device. He agreed that he testified that he did not find psychological evaluations to be particularly helpful prior to the placement of a temporary spinal cord stimulator. When asked whether a history of anxiety and depression prior to the alleged accident would have any impact upon his opinion as to whether Petitioner should have undergone a psychological evaluation prior to the placement of the stimulator, Dr. Kube responded that it did not. He testified that he could not recall a single time where somebody he recommended came back with an unfavorable psychological analysis, and that it had never shown itself to be of any value. (PX22).

On cross examination, Dr. Kube testified that on February 10, 2016, Petitioner reported a good result with the implantation of a temporary stimulator. He denied that a physical examination was performed on that date. He testified that his physician's assistant saw Petitioner on March 23rd, and that no physical examination was performed on that date. He testified that it was a medication management visit. He agreed that reviewed the utilization review report dated March 20, 2015 and agreed that Dr. Shapiro recommended non-certification of the placement of a temporary spinal cord stimulator. (PX22).

The IME report of Dr. Benjamin Crane dated March 12, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 1. The report noted that Petitioner was on December 20, 2013 helping a patient into a car, at which time he strained his back. It was noted that since that time Petitioner had had significant pain that he described in the square of his low back with pain going into the buttocks. It was noted that Petitioner had no real radicular-type symptoms with pain radiating down his legs, and that he had one episode of urinary retention for which he underwent a full work-up that demonstrated no evidence for cauda equina syndrome. (RX1).

The IME report noted that Dr. Crane's diagnosis was that of low back pain, morbid obesity and dietary surveillance counseling, and that he believed that Petitioner would benefit from a course of non-operative management including medications and physical therapy. The report indicated that Dr. Crane suggested that if the findings of the nerve conduction study continued to cause elements of concern, he would consider repeating the nerve conduction study by an independent doctor who specialized in nerve conduction studies. The report noted that Dr. Crane recommended that Petitioner be placed on light duty work restrictions for 3 weeks to include no bending, pulling, pushing or stooping, no lifting anything heavier than 10 pounds and no overhead lifting. The report indicated that Dr. Crane believed that the current diagnosis was a direct result of the work injury, and that the treatment to date had been appropriate for the injury-related diagnosis. It was noted that Dr. Crane believed that Petitioner had an excellent prognosis for a complete recovery and return to work without restrictions, and that he did not believe that Petitioner had reached maximum medical improvement as he had not undergone any treatments specifically directed at his low back pain. (RX1).

The IME report of Dr. Benjamin Crane dated December 11, 2014 was entered into evidence at the time of arbitration as Respondent's Exhibit 2. The report noted that Petitioner returned with continued complaints of pain in his low back with numbness and tingling into the buttocks but no real radicular symptoms. It was noted that Petitioner stated that when his pain became very severe he had to straight cath himself but apparently this had been going on for quite some time. It was noted that there was a request for a dorsal column stimulator. (RX2).

The IME report noted that Dr. Crane had opportunity to review the MRI of the lumbar spine of June 23, 2014, which demonstrated maintained lumbar lordosis and that overall, it was a relatively unchanged MRI scan of the lumbar spine. Dr. Crane indicated that he did not feel that there was anything surgically from a spinal fusion standpoint or a single decompression that would make Petitioner better. It was noted that Dr. Crane did not see any contraindications doing a trial dose of a column stimulator, and that if it provided him relief of his symptoms, Petitioner may benefit from a long-time implanted dorsal column stimulator but that he would leave that up to the pain management physicians. It was noted that the diagnosis as related to the reported injury was that of low back pain, and that Petitioner's prognosis for recovery was poor as he thought there were some psychological issues going on as well. It was noted that Dr. Crane thought it might be worth a try to do the dorsal column stimulator, but that he was very hesitant to say that it was going to be a definitive good option for Petitioner and that he would be hesitant to recommend anything surgically "but it is always worth a try." It was noted that Dr. Crane indicated that he saw no contraindication why Petitioner could not work full duty with the understanding that he would have back pain, and that at a minimum he should be able to work light duty. It was further noted that Dr. Crane would shy away from the dorsal column stimulator but it was worth a try, and that he would recommend doing a course of work hardening followed by an FCE. (RX2).

The records of Joyner Therapy Services were entered into evidence at the time of arbitration as Respondent's Exhibit 3. The records were effectively duplicative of those as contained in Petitioner's Exhibit 21. (RX3; PX21).

The letter of Dr. Shapiro dated March 20, 2015 was entered into evidence at the time of arbitration as Respondent's Exhibit 4. The utilization review letter referenced non-certification for the spinal cord stimulator trial proposed by Dr. Richard Kube. It was noted that Petitioner complained of chronic low back pain despite prior conservative care, that Petitioner had depression and anxiety and that there was no evidence of a failed back surgery. It was also noted that Petitioner's current pain complaints and deficits were not clearly outlined, and that without psychological clearance prior to a spinal cord stimulator trial, the medical necessity of the requested SCS trial was not established. (RX4).

The medical records of Urology Group of Paducah were entered into evidence at the time of arbitration as Respondent's Exhibit 5. Petitioner underwent cystourethroscopy on October 24, 2007 for a pre-operative diagnosis of urinary frequency, urgency and partial urinary retention and a post-operative diagnosis of normal appearing bladder and urethra. At the time of the October 17, 2007 visit, it was noted that for the last 2 months Petitioner had been troubled with increasing symptoms of prostatism and were characterized by straining, intermittency, hesitancy, no feeling of urgency to void but that when he got up in the morning he felt he had a little bit of discomfort in the lower abdomen. It was noted that prior to this onset, he had never had a urological problem. The impression was that of urinary frequency and urgency with partial urinary retention. Petitioner was recommended to undergo urodynamic testing as well as cystourethroscopy. The note of October 24, 2007 indicated that the bladder was absolutely normal and that they were waiting the results of the urodynamic study. (RX5).

The records of Urology Group of Paducah reflect that Petitioner was seen on February 10, 2011, at which time Petitioner was seen for unrelated issues and it was noted that he had never undergone the urodynamic study that had been previously recommended. (RX5).

The medical records of Dr. Hatchett were entered into evidence at the time of arbitration as Respondent's Exhibit 6. The records were effectively duplicative of those as contained in Petitioner's Exhibit 13. (RX6; PX13).

The transcript of the deposition of Dr. Noren dated May 26, 2016 was entered into evidence at the time of arbitration as Respondent's Exhibit 7. Dr. Noren testified that he is board-certified in

anesthesiology and pain management and that his practice is limited to treating people with chronic pain. (RX7).

Dr. Noren testified that he examined Petitioner on August 20, 2015, at which time Petitioner gave a history that he was lifting a patient while working as a paramedic, that the patient weighed 1,000 pounds and that he had the acute onset of back pain with no prior history of back pain. He testified that Petitioner reported pain in his lower back that radiated down to his legs to his knees, that it was in the posterior portion of his back and lateral portion of his legs, that it was constant, worse with sitting, standing and walking, and that any position he stayed in for greater than 15-30 minutes was painful. He testified that Petitioner's leg pain was burning and tingling, that it was constant but fluctuated in intensity, that the leg pain was worse with prolonged activity and that Petitioner had bladder symptoms and reported urinary retention. He testified that with respect to family history, Petitioner's father had chronic pain and apparently had a spinal cord stimulator placed. (RX7).

Dr. Noren testified that the Oswestry Disability Impairment questionnaire was a way of trying to objectify how pain interfered with an individual's life. He testified that Petitioner reported that his score was 64%, which would suggest that Petitioner was "crippled" and that back pain impinged on all aspects of a patient's life. He testified that the physical examination revealed normal pace and normal gait, a normal sensory exam, normal motor strength of his hip flexors, knee flexion/extension, ankle flexion/extension and movement of his toes up and down. He testified that Petitioner had symmetric reflexes and negative straight leg raising in the sitting position. He testified that Petitioner was able to reach his hands to his toes touching his toes without pain. He testified that Petitioner's whole exam was completely normal. (RX7).

Dr. Noren testified that he reviewed various medical records which were summarized in his report, and that the more recent note that he had available for Dr. Kube had no physical exam or medications and recommended a spinal cord stimulator trial. He testified that there were no medications listed, so it was hard to objectify how much pain a patient was having to justify a treatment that was for chronic pain. He testified that the exam by Dr. Jeffrey Jones in October of 2014 did not give an explanation for the urinary retention issues and suggested a spinal cord stimulator might be reasonable. He testified that the neurologic consult with Dr. Trudeau in February of 2014 noted bilateral S1 radiculopathy with some left extensor hallus longus weakness, but it was not present on the date of his examination and was not consistent with his exam. He testified that Petitioner's ability to stand on both feet making use of the S1 nerve root to stand and walk was not consistent with an S1 radiculopathy. (RX7).

Dr. Noren testified that his diagnosis was that of a lumbar strain and that many of his symptoms, specifically the urologic ones, were unrelated to the injury. He testified that there were no objective findings to explain Petitioner's unusual symptoms of urinary retention and priapism, and that they would not be explainable by the MRI showing degenerative L5-S1 disc nor by the EMG showing an S1 radiculopathy. He testified that he had opportunity to review various diagnostic imaging reports, and that there was nothing significant revealed in any of the diagnostic reports. He testified that the findings revealed on the diagnostic reports were not consistent with Petitioner's reported current impairment as of the date of the examination, and that Petitioner's exam was consistent with what was essentially a normal MRI with some mild degenerative changes that would be expected based on his age. (RX7).

Dr. Noren testified that the reported priapism and urinary retention were not consistent with any of the findings revealed by the diagnostic tests, and that if priapism was due to a lumbar spine issue, it would have to involve the sacral roots S2, 3 and 4. He testified that Petitioner's diabetes would explain the priapism. He testified that Petitioner's diabetes would also possibly be accountable for the urinary retention as well. He testified that diabetes can cause autonomic dysfunction, and that there was nothing on the MRIs that would objectively explain these symptoms. (RX7).

Dr. Noren testified that he was aware that Petitioner reported developing urinary retention after undergoing an epidural steroid injection. He testified that neither he nor his partner since 1993 had ever had that occur for multiple diagnoses across many age ranges of patients with and without other medical conditions. He testified that urinary retention following an epidural would be a sign of possibly an epidural hematoma, which Petitioner did not develop. He testified that the records suggested that Petitioner had been sent home without an explanation for the episode, and that in his review of the records he did not find any type of anatomic explanation for the report of urinary retention. He testified that the positive EMG findings might be due to Petitioner's diabetes. He testified that Petitioner did not have an S1 radiculopathy, which was consistent with the MRIs. He testified that Petitioner's reported impairment on the Oswestry Disability questionnaire was not consistent with his examination nor with the activities that he reported that he was able to go grocery shopping, laundry and normal activities of daily living. He testified that Petitioner also reported that he drove to the examination in Des Plaines from Paducah. (RX7).

Dr. Noren testified that he did not find any evidence on the scans that would explain the impairment that Petitioner was reporting with his normal examination. He testified that Petitioner should not have any interventional pain management because there was no good medical explanation for his symptoms from an orthopaedic or neurosurgical spine perspective and that it was likely that the symptoms were more related to an underlying medical condition such as diabetes. (RX7).

Dr. Noren testified that the indication for a spinal cord stimulator was back and leg pain associated with typically nerve injury. He testified that the main contraindication for a spinal cord stimulator was infection at the site. He testified that after placement of the stimulator, Petitioner would have restricted range of motion of his spine so he would have less function after the stimulator was placed than he had at the time that he was seen after driving from southern Illinois. He testified that you cannot have the stimulator on while driving, which was why Petitioner's father did not drive. (RX7).

Dr. Noren testified that Petitioner's burning and tingling pain could be related to his diabetes, so the possibility that it was unrelated certainly would be consistent with his urinary retention and priapism as having an underlying diabetic neuropathy. He testified that there was no mechanical explanation for Petitioner's neuropathic complaints based on the MRI and CT scans. He testified that Petitioner was on two different narcotics which was not recommended treatment, and that the basis of using one narcotic was that there was less chance of diversion, overdose and abuse. He testified that the Gabapentin was indicated for Petitioner's subjective complaints and would be an expected treatment that may be beneficial for his peripheral neuropathy that was associated with his diabetes. (RX7).

Dr. Noren testified that it appeared that Petitioner was functioning at a light duty level that was based upon an FCE as well as his examination. He testified that he thought Petitioner appeared to be functioning at at least a level of 15 pounds and to objectively measure him with an FCE might be warranted. (RX7).

Dr. Noren testified that subsequent to the IME he had opportunity to review additional medical records and materials, including the IME report of Dr. Crane dated December 11, 2014, medical records of Dr. Kube, and the transcript of the deposition of Dr. Kube. He testified that when he examined Petitioner, he did not find any evidence of a saddle paresthesia. He testified that the fact that Dr. Kube in his initial note of January 2014 reportedly found a saddle paresthesia did not have any impact upon a possible recommendation for a spinal cord stimulator because stimulation was not indicated specifically for a saddle parethesia and that it was certainly not indicated for the treatment of bladder impairment. He testified that a spinal cord stimulator would be prescribed for back and leg pain. (RX7).

Dr. Noren testified that he reviewed medical records of urologic testing prior to his injury in 2013, and that he had urologic testing for complaints of bladder symptoms. He testified that Petitioner's

subjective bladder symptoms pre-existed the injury of December of 2013. He testified that he did not think it was possible that Petitioner's accident might have caused or aggravated benign prostatic hypertrophy. He testified that he opined that the temporary spinal cord stimulator was not indicated given that Petitioner likely has a diabetic neuropathy, does not have any nerve root impingement that would be expected to respond and that his impairment and disability were not consistent with the reported activities. He testified that the recommendation of the temporary spinal cord stimulator was not related to the alleged accident. He testified that the permanent spinal cord stimulator was not indicated given his opinion that Petitioner did not need the trial. (RX7).

On cross examination, Dr. Noren denied that he was a neurologist or a neurosurgeon. He agreed that he reviewed Dr. Jones' October 16, 2014 note where he indicated that a spinal cord stimulator was appropriate as the treatment for the L5-S1 annular tear was non-surgical. He agreed that the interpretive report for the MRI of January 7, 2014 suggested that Petitioner had a left paracentral herniation at L5-S1. He agreed that Petitioner reported that he had never had any prior back injuries before the December 2013 accident. He testified that Dr. Trudeau's assessment that Petitioner had an S1 radiculopathy was not consistent with his examination. (RX7).

On cross examination, Dr. Noren agreed that Petitioner's ongoing back pain would be consistent with an injury while lifting a 1,000-pound patient. He admitted that he did not know how many miles Petitioner had to drive to get to his office, and he testified that he did not know how many times or if he had to stop during that drive. He testified that he did not know why Petitioner drove up the night before. He testified that he did not know whether Petitioner was taking any medication during that drive, but that he had taken a Lortab at 3:00 p.m. that day. He agreed that the appointment was at 3:00 p.m. (RX7).

On cross examination, Dr. Noren agreed that he was aware that Petitioner had undergone a trial dorsal spinal stimulator. He testified that if Petitioner's pain improved form a 7-8 to a 4 after the trial stimulator, it was possible that a stimulator would help improve Petitioner's radicular symptoms. (RX7).

On redirect examination, Dr. Noren testified that he also reviewed the December 27, 2013 CT from Massac Memorial Hospital, the lumbar CT dated January 24, 2014 from Harrisburg Medical Center and the lumbar MRI from Western Baptist Hospital dated January 25, 2014, and that they did not have the left paracentral herniation recorded, that one of them recorded an annular tear central at L5-S1 with a small left paracentral disc protrusion and that none of them showed any nerve root impingement. (RX7).

On redirect examination, Dr. Noren testified that in his review of the medical records of Dr. Kube both pre- and post-implantation, the January 2016 note prior to the stimulator referenced an ODI of 58 and that the trial was on February 1st. He testified that the note on February 10th noted an ODI of 62, which had increased with the stimulator and was not consistent with improvement in pain. (RX7).

An e-mail from Respondent's counsel to Petitioner's counsel dated June 21, 2016 addressing outstanding medical bills was entered into evidence at the time of arbitration as Respondent's Exhibit 8.

CONCLUSIONS OF LAW

The parties stipulated at the time of hearing that on December 20, 2013, Petitioner sustained accidental injuries that arose out of and in the course of his employment. (AX1).

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner has met his burden of proving that his current condition of ill-being is causally related to the accident.

The Arbitrator notes that Dr. Kube testified that he believed that Petitioner's current condition of ill-being was related to the accident that occurred in December of 2013. He testified that in the absence of anything previous of significance and an immediate onset, it was likely that the incident caused the problems that Petitioner was having. He testified that he believed that the trial dorsal stimulator was reasonable and necessary to address the condition of ill-being in Petitioner's low back, and that he thought Petitioner was a good surgical candidate for the permanent placement of the stimulator. (PX22). The Arbitrator also notes that Dr. Jones thought a spinal cord stimulator was a reasonable approach as Petitioner's symptoms were unlikely to respond to surgical intervention. (PX20). The Arbitrator further notes that Dr. Crane opined that the diagnosis as related to the reported injury was that of low back pain, and that as of the time of the December 11, 2014 visit, he thought it might be worth a try to do the dorsal column stimulator, but that he was very hesitant to say that it was going to be a definitive good option for Petitioner and that he would be hesitant to recommend anything surgically "but it is always worth a try." (RX2). While the Arbitrator acknowledges that Dr. Noren did not recommend a spinal cord stimulator, he agreed that Petitioner's ongoing back pain would be consistent with an injury while lifting a 1,000-pound patient. (RX7).

Based upon the foregoing, the Arbitrator finds that Petitioner met his burden of proving that his current condition of ill-being is causally related to the accident of December 20. 2013.

With respect to disputed issue (J) pertaining to medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary and causally related to his work accident of December 20, 2013. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibits 1-11, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to prospective medical treatment, in light of the Arbitrator's finding as to the issue of causation, the Arbitrator finds that Respondent shall authorize the treatment recommended by Dr. Kube, including the dorsal spinal cord stimulator.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hermelinda Arellano,
Petitioner,

vs.

NO: 12WC 550

17IWCC0505

Wahl Clipper,
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, permanent disability, temporary total disability, causal connection, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $36,500.00. 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.

AUG 18 2017

DATED:
o081517
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARELLANO, HERMELINDA
Employee/Petitioner

Case# **12WC000550**

12WC036235

WAHL CLIPPER
Employer/Respondent

17IWCC0505

On 12/14/2015, 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 0.53% 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:

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

17IWCC0505

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

Hermelinda Arellano
Employee/Petitioner

v.

WAHL CLIPPER
Employer/Respondent

Case # **12** WC **00550**

Consolidated cases: **12 WC 36235**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **November 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **10/18/10**, 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 this accident ***was*** given to Respondent.

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

In the year preceding the injury, Petitioner earned **$20,153.69**; the average weekly wage was **$438.12**.

On the date of accident, Petitioner was **49** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and **$1,932.28** for nonoccupational indemnity disability benefits, for a total credit of **$1,932.28**.

Respondent is entitled to a credit of $23,284.67 for medical bills paid through its group medical plan for treatment from 10/18/10 through 5/16/11, under Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 7-6/7 weeks, commencing 11/23/10 through 1/16/11, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services listed in Petitioner's Group Exhibit 2 (PX 2.1 through 2.8), for treatment from 10/18/10 through 5/16/11, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $330.00/week for 66.625 weeks, because the injuries sustained caused the 17.5% loss of the right hand (35.875 weeks) and 15% loss of the left hand (30.75 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.

D. Dyas McCarty

12/9/2015

DEC 14 2015

Signature of Arbitrator Date

FINDINGS OF FACT

The Petitioner has filed two claims, which are referenced in the caption of this decision and which have been consolidated for arbitration. The claims involve repetitive trauma injuries to the Petitioner while she was employed by the Respondent. While two separate decisions will be issued, the Arbitrator will use one set of facts for both decisions.

The Petitioner, Hermelinda Arellano, testified that she started working at Wahl Clipper on or around November 9, 2009. Petitioner began working at Wahl Clipper through a temporary agency in November of 2009, but Petitioner was officially hired and became an employee of Wahl Clipper around April of 2010. Wahl Clipper is a manufacturer of hair clippers for humans and pets. Petitioner testified that she began and continued working at Wahl Clipper as a packer of the hair clippers. She testified that she worked 10 hours a day for 5-6 days a week. Petitioner received two ten minute breaks and a thirty minute lunch break.

Petitioner testified that she is right handed and as a packer she would receive the trimmers from another operator and grab whichever box or blister the order called for. There were a couple different types of trimmers that would require a certain box, or blister as they call it. A blister is a plastic insert that the trimmer pieces are put into and then sealed and put into a trimmer box. She would use both hands to quickly put trimmers, instructions and accessories into each container. She would push together the blister handles, requiring pinch and finger force. Once they were packed, she would place them into larger boxes for shipping and then tape or seal the boxes and stack them on a nearby pallet.

Respondent entered into evidence a disk, containing a video that shows a co-worker of the Petitioner performing some type of assembly job. (RX 3). The video does not identify what job is being performed. The worker is seen putting blades onto a trimmer body and securing the blades with screws that are put in by another machine. The partially completed trimmer is then put in a tote and the process is repeated. The person used both hands to quickly put the trimmer blades onto the body of the trimmer and then into a tote.

Petitioner testified that she did not have any problems with her hands/wrists prior to starting her work at Wahl Clipper in November of 2009.

Petitioner testified that she began to experience gradually increasing pain and numbness in both of her hands/wrists as she performed her work duties at Wahl Clipper. On August 19, 2010, she was seen by Dr. Afrem Malki at CGH Medical Center and complained of numbness in the finger of both hands for the past several weeks that got worse recently. Dr. Malki referred Petitioner for an EMG study. Those records are contained in PX 4 (Dr. Vinje deposition), as deposition exhibit 2. Petitioner underwent an EMG and was referred to Dr. Vinje at the Sterling Rock Falls Clinic.

On October 18, 2010, Petitioner presented to Dr. Thomas Vinje at the Sterling Rock Falls Clinic (name subsequently changed to CGH Main Clinic), upon referral from Dr. Malki. (PX 1.1). She described numbness and tingling in the hands, worse on the left. She indicated her duties at Wahl Clipper in the packing department. Dr. Vinje identified and reviewed her EMG and nerve conduction velocity studies disclosing bilateral mild

carpal tunnel syndrome and that she had not had conservative treatment. On examination, she had a negative Tinel's, negative Phalen's and negative Adson's. She was given Celebrex and wrist splints and told to follow up in two weeks to determine whether she has had improvement or not.

Petitioner remained under Dr. Vinje's care from October 18, 2010 through May 16, 2011 for the bilateral carpal tunnel syndrome. (PX 1.1). On November 15, 2010, Dr. Vinje noted that she had no improvement with the Celebrex and wrist splints and that conservative treatment had failed. Dr. Vinje recommended surgery. On November 23, 2010, Dr. Vinje performed carpal tunnel surgery on Petitioner's right hand/wrist. On December 14, 2010, Dr. Vinje performed carpal tunnel surgery on Petitioner's left hand/wrist.

Petitioner was off work from November 23, 2010 through January 16, 2011. On January 17, 2011, Petitioner returned to her regular job full time. She returned to the packing job that she was doing previously and stayed in that job until approximately March of 2011. She testified that during this phase of the packer position, she had a lot of problems with the tape machine and would have to tape by hand. She was working 8 hour days 5-6 days per week and she would have two ten minute breaks and one thirty minute break. The packing rate for this job was about 1300 clippers per shift. The Arbitrator finds Petitioner credible and unrebutted.

Approximately March of 2011, Petitioner was moved to a job called "nosepieces." She worked in this job until to approximately May of 2011. Her job duties required her to hold the clipper casing with her left hand and press the trigger piece into the clipper with the right hand and then put the casing into a machine that put on the nosepiece. She would have to put the screws into the nosepiece. She would then take the clipper to another machine where the blade and lever would be put on. She would use both hands throughout the process and the rate for this job was approximately 1300 clippers per shift. She also testified that once the clipper was assembled, she would put them on a skid, which would have to be moved with an old crane that was very hard to move and she would move that skid to the warehouse.

On May 16, 2011, Petitioner was last seen by Dr. Vinje for her bilateral carpal tunnel and she was released at MMI for the bilateral carpal tunnel. Dr. Vinje noted that she had shown improvement with physical therapy and home exercise, but still had some discomfort in the little fingers. She was advised that there was nothing more to offer her other than for her to allow time for improvement.

In approximately May of 2011, Petitioner was moved to another job called "first cut" and was on this job for about a month. Petitioner testified that she would use both hands to put a laser and high pot onto the clippers and then test the clipper to make sure it worked properly. If the clipper did not work well enough, then she would have to completely clean the clipper with a blow machine using her left hand to hold the clipper and turn it over while she used the blow machine and she would then restart the testing process. She would also use both hands to put oil and a blade guard onto the clipper. The rate for this job was approximately 800 clippers during an eight hour shift.

Petitioner was then moved to a different job called "packing the fourth operator," in approximately June of 2011 and worked this job for approximately two months until August of 2011. She testified that she would hold a clipper with her left hand, tighten the screws on the clipper blade, put the clipper in a machine to put the cap on and then test the clipper to make sure it worked. If the blade was not straight, then she would hold the clipper in her left hand and use her right hand to hit the blade with a hammer until the blade was straight. She would then put the clipper back in the machine, take it back out, attach a power source and retest the clipper. The rate for this job was 800 to 1000 clippers in an eight hour shift.

In approximately August of 2011, Petitioner was moved to a job called "Lapping." This job involved

putting clipper blades onto a lapping machine to grind the surface of the clipper blade. The lapping machine had two or three grinding wheels on it and two arms attached to each wheel. A clipper blade was attached to each machine arm and Petitioner would then manually press the machine arms down against the grinding wheel. The process involved vibration and manual force. Once the wheel had finished the process, the arms were raised again to remove the blades and the process was started over with new blades. The rate for this job was between 300-500 blades per hour.

Petitioner testified that after returning to work in January of 2011 and working the different areas, she began to experience gradually increasing pain in her left hand/wrist. She said that her pain began while working on the nosepiece job. She did not have any numbness like she did with the carpal tunnel issues, but she only had pain and the pain was different than what she experienced with the carpal tunnel condition. The pain was located on the top of her hand, in the area proximal to her thumb. She said the pain radiated up into her forearm, and that there was swelling proximal to her thumb. On June 20, 2011, Petitioner reported her problems to her supervisor and the company nurse. She continued to complain of the problems with her left hand to her supervisor and an accident report was completed on July 19, 2011. In the report, the Petitioner identified the nosepiece job as the one bringing on her symptoms which she said were on the top side of the left wrist. (RX 2). The Respondent then sent Petitioner to the company physician at Now Care. (PX 1.4).

On July 20, 2011, Petitioner presented to Dr. Craig Michelsen at Now Care. Petitioner continued her treatment at Now Care with Dr. Michelsen and Dr. Grubb from July 20, 2011 through September 1, 2011. (PX 1.4). On July 20, 2011, Petitioner indicated left wrist pain that was worse in the morning and that had been going on for one month. On examination, Dr. Michelsen noted wrist tenderness on palpation of the radial aspect of the left wrist. Pain was elicited by motion. She was prescribed a cock-up splint to be worn at work, a thumb spica splint and given a prescription for prednisone. On July 27, 2011, she had no improvement, she was to continue using the splint and prescribed physical therapy. On August 5, 2011, Dr. Grubb noted that she still had no improvement and physical therapy was not helping. She was diagnosed with DeQuervain's tenosynovitis and told to continue physical therapy. On August 19, 2011, Dr. Grubb noted that she noticed some improvement and she was told to continue splinting and Tramadol. On September 1, 2011, Dr. Grubb diagnosed Petitioner with DeQuervain's tenosynovitis and continued the splinting and prescriptions for pain medication. Dr. Grubb indicated that she should continue a home exercise program and to follow up as needed.

On September 12, 2011, Petitioner returned to see Dr. Thomas Vinje. (PX 1.1). Petitioner described the problems that she was having with her left hand when she works. She described the job activity of "packing the fourth operator" and using the hammer to realign the clipper blades. Dr. Vinje noted that she had developed ulnar neuritis at the little finger, trigger finger of the same finger and left deQuervains tenosynovitis. Petitioner was put on light duty with minimal left-handed work for next three weeks and given a two week supply of Celebrex.

On September 26, 2011, Dr. Vinje noted that she had some improvement with Celebrex, but had stomach irritation as a result of it and based on this she was placed her on tramadol 50mg. If she failed to improve with the tramadol, then Dr. Vinje indicated she may need to undergo surgery. On December 26, 2011, Dr. Vinje noted continued soreness and intermittent numbness in the left hand, as well as weakness. She was referred to Dr. DelaCruz for a repeat EMG. On January 11, 2013, the EMG was obtained, compared to the previous study on September 22, 2010, and showed no evidence for any focal nerve entrapment. On February 6, 2012, Dr. Vinje noted continued complaints of discomfort in the area of the first dorsal compartment. He did not believe that an injection would be beneficial and referred her to Dr. Brian Bear at Rockford Orthopedic Associates for a second opinion. On April 2, 2012, Dr. Vinje notes that Petitioner was unable to see Dr. Bear because of incomplete paperwork. Petitioner testified that the Respondent was disputing her claim and she was

unable to get authorization to be seen and unable to pay for the treatment herself. Dr. Vinje recommended surgery. On April 18, 2012, Dr. Vinje performed a left first dorsal compartment release, including accessory compartment.

Petitioner was taken off work as of April 17, 2012 by Dr. Vinje.

Petitioner continued her care and treatment with Dr. Vinje through January 30, 2013. (PX 1.1). On May 7, 2012, Dr. Vinje injected the first dorsal compartment area with Depo-Medrol and Xylocaine. On May 14, 2012, Dr. Vinje noted that Petitioner did not have significant relief from the injection. On June 18, 2012, Dr. Vinje referred Petitioner to Dr. Ibarra for evaluation and possible treatment. Petitioner was unable to be seen by Dr. Ibarra. Between June and October of 2012, Dr. Vinje's records reveal numerous phone call records indicating attempts to have Petitioner seen for a second opinion. On June 28, 2012, Dr. Bear's office indicated that they could not see Petitioner and suggested a Dr. VonGillern. On July 2, 2012, Petitioner requested a referral to Dr. Charles Carroll. An appointment with Dr. Carroll was scheduled for July 23, 2012. However, Petitioner had to cancel the appointment because she was unable to afford payment up front to see Dr. Carroll. On October 11, 2012, Dr. Vinje's records confirm that Petitioner was unable to see Dr. Ibarra without authorization from the Respondent. Dr. Vinje then ordered a functional capacity evaluation.

On January 30, 2013, a FCE was obtained at KSB Medical Group. (PX 1.6). Petitioner participated in a one day functional capacity evaluation. The report indicates that Petitioner participated in the FCE to the best of her ability and that she was functioning at the medium physical demand level with lifting restrictions of 20 - 50 pounds occasionally, 10 - 25 pounds frequently, and 10 pounds constantly. She did appear to struggle with left hand carrying, performing 10 pounds less than the right. She reported pain with various activities or trials during the FCE, but it did not appear to alter her performance. The FCE recommended continued job duties within the medium physical demand level. The FCE also indicated that she might benefit from physical or occupational therapy to help address the pain in the left hand and any range of motion, strength or flexibility issues causing the pain in her left hand.

Petitioner testified that the Respondent refused to accommodate the restrictions, per the FCE, and she remained off work.

On March 13, 2013, Petitioner returned to see Dr. Afrem Malki at the CGH Medical Center. Petitioner continued her care and treatment with Dr. Malki through October 4, 2013. (PX 1.1). She complained of pain and numbness sensation in the palm of the left hand as well as the left little finger. She was again referred to Dr. Delacruz, a neurologist, for a second opinion regarding the numbness and pain in the left palm and left 5th finger. She was also advised to use a wrist splint.

Petitioner testified that on April 17, 2013, she was terminated from her employment with Wahl Clipper because she was only allowed to be off work for one year and the year had expired. The Respondent did not offer to accommodate Petitioner's restrictions and Petitioner remained off work through the date of trial. She said that she has not looked for work, electing to wait and see if her hand symptoms would be treated.

On May 24, 2013, Petitioner followed up with Dr. Malki. She had continued complaints about her left wrist, despite the surgery by Dr. Vinje and the injection of cortisone, as well as physical therapy. On June 13, 2013, Petitioner was able to be seen by Dr. DelaCruz at the CGH Medical Center. Dr. Malki had referred Petitioner. Dr. DelaCruz reviewed the prior treatment, the continued symptoms and diagnosed Petitioner with an ulnar nerve lesion, suspecting either cubital tunnel syndrome or entrapment at Guyon's Canal. He recommended another EMG study. On July 31, 2013, the EMG study was obtained and did not show any ulnar nerve entrapment at the left wrist or elbow and no evidence for cervical spine radiculopathy. On August 9,

2013, a MRI of the left wrist was obtained and revealed: a suspected tear in the volar aspect of the scapholunate ligament; Tenosynovitis of the extensor carpi radialis; Degenerative change with subchondral cystic edema of the lunate; questionable erosion of the triquetrum; and unremarkable radiocarpal joint. There were no other findings in this exam to suggest rheumatoid arthritis.

Petitioner testified that she continued to follow up with Dr. Malki through October 4, 2013 and continued to seek an orthopedic surgeon that would see her for a second opinion.

Petitioner, pursuant to Section 12, then requested Dr. Charles Carroll to review her treatment records, perform an examination and give his opinions regarding the causation of her injuries and his recommendations for any further treatment. Dr. Carroll prepared three reports, dated April 23, 2014, August 1, 2014, and August 15, 2014. These reports are included in the record as PX 5, 6, and 7. The report of August 1 was done after his only examination of the Petitioner.

The Respondent introduced the evidence deposition of their Section 12 examiner, Dr. Jay Pomerance, a hand surgeon. (RX 1). Dr. Pomerance's examination took place on September 25, 2014. Dr. Pomerance has not personally visited the Wahl Clipper plant, nor witnessed the work activity first hand. Dr. Pomerance does not relate Petitioner's conditions of ill-being (bilateral carpal tunnel syndrome or deQuervain's tenosynovitis) to her work activities. Dr. Pomerance testified that he believed Petitioner's conditions of ill-being are related to other risk factors, such as: age, gender, menopause status, as well as obesity. However, Dr. Pomerance agrees with the diagnoses of Petitioner's conditions of ill-being and that the treatment Petitioner received was reasonable and necessary. Dr. Pomerantz also opined that the Petitioner had no evidence of an intersection syndrome between the first and second dorsal compartments, as found by Dr. Carroll. He did find an impaction of the ulna, but said that it was not causally related to the Petitioner's work duties because she did not have unusual wrist postures or forces which were associated with that condition. He said that the condition developed gradually due to the length discrepancy between the ulna and radius. (RX 1 at 12)

Petitioner presented the evidence deposition of Dr. Thomas Vinje. (PX 4). Dr. Vinje is board certified in orthopedic surgery. Dr. Vinje treated and took Petitioner to surgery for her bilateral carpal tunnel conditions and the first dorsal compartment syndrome. Dr. Vinje is personally familiar with Petitioner's place of employment and has personally toured Respondent's plant and witnessed the work activities first hand. (PX 4 at pp 18, 34-35, 75, 77). Dr. Vinje was provided with hypotheticals of Petitioner's job duties. (PX 4 at pp. 29-32, 51-55). Dr. Vinje causally relates Petitioner's bilateral carpal tunnel syndrome and left deQuervain's tenosynovitis and the treatment that Petitioner received to her work activities with Respondent. (PX 4 at pp. 33, 42-43, 57-58, 84).

Petitioner presented the evidence deposition of Dr. Charles Carroll. (PX 8). Dr. Carroll is board certified in orthopedic surgery. Pursuant to Section 12, Dr. Carroll was asked to review Petitioner's treatment records, perform a physical examination of Petitioner, and provide his opinions on the causation of Petitioner's conditions of ill-being and what, if any, his recommendations for treatment would be. Dr. Carroll reviewed all of Petitioner's treatment records, Dr. Vinje's deposition testimony, Respondent's job video and job description (RX 3), and the Dr. Pomerance's reports. (PX 8 at pp. 9-10, 18-19). Dr. Carroll examined Petitioner on August 1, 2014. Dr. Carroll's diagnosis of Petitioner is resolved bilateral carpal tunnel syndrome, left hand intersection syndrome, residual tendonitis, and TFCC issue/tear. Dr. Carroll causally relates Petitioner's conditions of ill-being to her work activities. (PX 8 at pp.19-22, 36-39). Dr. Carroll recommends further treatment of an injection to the second compartment of the left hand and a MRI or the left hand/wrist to consider the issue of the triangular fibrocartilage complex. (PX 8 at pp. 23-24).

Petitioner testified as to what she currently notices about her hands following the bilateral carpal tunnel

surgeries. She testified that she continues to have pain in both hands/wrists, more so in the evenings after using her hands throughout the day. She also has numbness in the hands/wrists on a daily basis and that the numbness is mostly in the first three fingers. She has weather sensitivity and has weakness with gripping.

Petitioner testified as to what she notices about her left hand/wrist, related to her work duties for the accident date of June 20, 2011. She testified that the pain she is experiencing in her left hand/wrist is different than the pain/numbness she experiences with the bilateral carpal tunnel conditions. She testified that she has pain in the top of her hand and along the side of her wrist/hand on the thumb side, which extends up her forearm on the thumb side of her forearm. Petitioner testified that she would like to follow Dr. Carroll's treatment recommendations for her left hand/wrist.

CONCLUSIONS OF LAW

On the issues of accident and causation, the Arbitrator makes the following conclusions of law:

The Petitioner's testimony concerning her job duties while working at the Respondent's facility are unrebutted. She was a packer from November 2009 until she began her treatment for bilateral carpal tunnel in August 2010. The job required her to use her hands in a repetitive fashion at a fast paced job throughout the course of her work day. The job required her to forcefully pinch and push with each hand. The video corroborates her testimony.

Her first treatment wherein she complained of finger numbness was on August 19, 2010 with Dr. Malki. Prior records from the doctor show complaints in February 2009 of neck pain and in May 2010 of neck and left shoulder pain. She was found to have mild degeneration of the cervical spine. The only reference to numbness is contained in the doctor's note of April 14, 2010, which was five months after she began her work as a packer. The complaint also references the arm as opposed to the hand.

Once she began treatment, her complaints remained consistent until surgery was performed. Dr. Vinje testified that her job required repetitive use of the hands in a relatively vigorous fashion for long hours each work day. He said she had repetitive flexion of her wrists, with repetitive gripping and use of the fingers which was causally related to her condition. (PX 4 at 33, 34) He acknowledged that she had some other risk factors for the condition, but maintained that the primary factor was her work. (Id at 77) The Arbitrator finds Dr. Vinje's testimony persuasive.

The Arbitrator finds that Petitioner's bilateral carpal tunnel syndrome is related to her work as a packer at the Respondent's facility. The date of accident for this repetitive injury is October 18, 2010, the date of her nerve conduction studies which confirmed the condition.

On the issue of medical services that were provided to Petitioner, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates his above findings with respect to the Respondent's liability for medical bills. Respondent's only objection to awarding medical bills to Petitioner was one of liability. The medical bills are contained in the record as Petitioner's Group Exhibit 2 (PX 2.1 through 2.8). Given the findings set forth above, The Arbitrator finds that the Respondent is ordered to pay to the Petitioner amounts for the medical related to the care, diagnosis and treatment of her bilateral carpal tunnel from October 18, 2010 through May 16, 2011, pursuant to the Fee Schedule. Respondent is entitled to credit for medical under Section 8(j) for bills paid.

With respect to temporary total disability benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates his above findings.

With respect to temporary total disability benefits related to the bilateral carpal tunnel claim (12 WC 00550), it appears from the evidence and Dr. Vinje's records that his active treatment of the Petitioner's bilateral carpal tunnel ended on or about May 16, 2011. Petitioner was taken off work on November 23, 2010 and returned to work on January 16, 2011. Accordingly, the Respondent is liable for TTD payments from November 23, 2010 through January 16, 2011, a period of 7 6/7 weeks. Respondent is entitled to credit for non-occupational weekly benefits in the amount of $1,932.28, paid during the above time frame.

With regards to the nature and extent of the injury, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates his above findings.

The Arbitrator notes that Petitioner is a 54 year old female who worked in very repetitive positions in Respondent's factory that produces hair clippers

Petitioner testified that she has continued complaints with both of her hands, experiencing pain and numbness. She also experiences hand weakness and weather sensitivity.

She complained of sensitivity of the scar on her left hand post surgery, and was prescribed anti vibration gloves on March 14, 2011 by Dr. Vinje. She continued to complain of numbness and weakness of the let hand to the doctor on December 26, 2011. Similar complaints were made to Dr. Malki in March and August of 2013. Finally, Dr. Carroll testified that her bilateral numbness and tingling reported during his exam in August 2014 represented residuals of her carpal tunnel syndrome. (PX 8 at 18)

The Arbitrator finds Petitioner sustained a loss of use of 17.5% of the dominant right hand and 15% loss of use of her left hand as a result of the injury on October 18, 2010.

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

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Hermelinda Arellano,
Petitioner,

vs.

NO: 12WC 36235

17IWCC0506

Wahl Clipper,
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, permanent disability, temporary total disability, causal connection, nature and extent and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 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.

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $30,400.00. 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 18 2017
o081517
MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

ARELLANO, HERMELINDA
Employee/Petitioner

Case# **12WC036235**

12WC000550

WAHL CLIPPER
Employer/Respondent

17IWCC0506

On 12/14/2015, 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 0.53% 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:

0021 REESE & REESE
TODD S REESE
979 N MAIN ST
ROCKFORD, IL 61103

1408 HEYL ROYSTER VOELKER & ALLEN
KEVIN J LUTHER
120 W STATE ST 2ND FL
ROCKFORD, IL 61105

17IWCC0506

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

Hermelinda Arellano
Employee/Petitioner

v.

WAHL CLIPPER
Employer/Respondent

Case # **12** WC **36235**

Consolidated cases: **12 WC 00550**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Douglas McCarthy**, Arbitrator of the Commission, in the city of **Rock Island**, on **November 4, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

Petitioner's current condition of ill-being with respect to the left DeQuervain's *is* causally related to the accident; the other diagnosed conditions are not.

In the year preceding the injury, Petitioner earned **$20,153.69**; the average weekly wage was **$438.12**. AWW is for all consolidated claims.

On the date of accident, Petitioner was **49** years of age, ***married*** with **3** dependent children.

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

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

Respondent shall be given a credit of **$0.00** for TTD, **$0.00** for TPD, **$0.00** for maintenance, and for nonoccupational indemnity disability benefits paid during the period when the Petitioner was entitled to temporary total disability benefits, referenced below.

Respondent is entitled to a credit for medical bills paid through its group medical plan for treatment from 7/20/11 through 1/30/13, pursuant to Section 8(j) of the Act.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $330.00/week for 41 2/7 weeks, commencing 4/17/12 through 1/30/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services listed in Petitioner's Group Exhibit 2 (PX 2.1 through 2.8), for treatment from 7/20/11 through 1/30/13, as provided in Sections 8(a) and 8.2 of the Act; the remainder of the bills are not the Respondent's responsibility as they are for treatment not causally related to the accident.

Petitioner's total disability following this accident is 25 % of the left hand; Respondent is entitled to a credit of 15 % of said hand per the decision in the companion case, 12 WC 00550. Accordingly, the Respondent is ordered to pay 10 % of the hand, 20.5 weeks, to the Petitioner as a result of this injury.

Petitioner's claim for prospective medical 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.

12/09/2015

DEC 14 2015

FINDINGS OF FACT

The Arbitrator notes that on February 4, 2013, Petitioner's application for adjustment of claim as filed in case number 12 WC 36235 (d/a 6/20/11) was consolidated with case number 12 WC 00550 (d/a 10/18/10).

The Arbitrator has filed his decision in claim number 12 WC 00550 and incorporates his findings of fact in this claim.

CONCLUSIONS OF LAW

On the issues of accident and causation, the Arbitrator makes the following conclusions of law:

Following her return to work after her carpal tunnel surgeries, the Petitioner resumed her regular job as a packer. She switched to the nosepiece job in March 2011, and testified that she began to have pain and swelling over the area identified by Dr. Vinje as the first dorsal compartment. In approximately June, she transferred to the First Cut job. A month later, she switched to the Assist job, a job which required holding clippers with her left hand while hammering their blades with her right. She complained to Now Care on July 20, 2011 of left wrist pain beginning one month earlier. On exam, she had pain over the radial aspect of the wrist. (PX 1.4) She followed up on July 27, 2011, and was found to have a positive Finklestein test, compatible with DeQuervains Syndrome. (Id) On August 5, 2011, her doctor at Now care diagnosed the condition. (Id)

The Petitioner then went back to Dr. Vinje for care on September 12, 2011 with pain in the left hand which she attributed to her hammering job. (PX 4 at 44-46) He diagnosed her with DeQuervain's, along with a trigger finger of the fifth finger and ulnar neuritis. She continued to treat with the doctor for the DeQuervain's, and eventually surgery was performed on April 18, 2012. Dr. Vinje testified that the DeQuervain's was causally related to the various jobs she performed after her return from carpal tunnel surgery. He said that she had repetitive flexion of the wrist along with repetitive percussion and vibration on those jobs. (Id at 57)

On the other hand, Dr. Vinje gave no explanation as to how the Petitioner's work could have been related to her trigger finger or ulnar neuritis. There are no other medical opinions in the record establishing said causation, and the Arbitrator is unable to reasonably presume that causation exists. According, the Arbitrator finds no causation between the Petitioner's work and those two conditions.

Finally, Dr. Carroll found the Petitioner with ulnar wrist pain and diagnosed a possible tear of the TFCC cartilage. He said the condition was the result of the Petitioner's repetitive work and her ulnar variance, a congenital condition leading to destruction of the cartilage.

The facts show that the Petitioner last worked at the Respondent's facility on April 17, 2012, the day prior to her DeQuervain's surgery. As of that date, there are no medical records showing any complaints by the Petitioner which would correspond with an injury to the TFCC or the left ulna. It wasn't until the June 13, 2013 note from Dr. DeLaCruz the ulnar neuropathy was diagnosed, after which nerve conduction studies were ordered.

Dr. Carroll agreed on cross-examination that if the Petitioner had not worked for an extended period of time for the Respondent prior to the discovery of her ulnar condition, the more likely it was related to her ulnar variance and not her work. (PX 8 at 35) June 13, 2013 is fourteen months after the Petitioner last worked. The Arbitrator concludes that the period is too long, given the medical opinions above, to establish a causal relation between work and said condition.

In summary, the Petitioner has shown a causal relationship between her work and her DeQuervain's tenosynovitis, but has not shown such a relationship with any of the other conditions diagnosed.

On the issue of medical services that were provided to Petitioner, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates his above findings with respect to the Respondent's liability for medical bills. Respondent's only objection to awarding medical bills to Petitioner was one of liability. The medical bills are contained in the record as Petitioner's Group Exhibit 2 (PX 2.1 through 2.8). Given the findings set forth above, The Arbitrator finds that the Respondent is ordered to pay to the Petitioner amounts for the medical related to the care, diagnosis and treatment of her left DeQuervain's tenosynovitis, pursuant to the Fee Schedule. Respondent is entitled to credit for medical under Section 8(j) for bills paid for that condition..

With respect to temporary total disability benefits, the Arbitrator makes the following conclusions of law:

The Arbitrator incorporates his above findings.

With respect to temporary total disability benefits related to the left hand condition of ill-being, it appears from the evidence and Dr. Vinje's records that Petitioner was taken off work as of April 17, 2012. After appropriate post surgical care, Petitioner underwent an FCE on January 30, 2013. The testing, deemed valid, found the Petitioner able to perform at medium work level. Dr. Carroll testified that at that level, the Petitioner could perform the duties of her past employment. (PX 8 at 34) The Petitioner has elected not to try to work since that date. As noted above, her treatment since then has primarily been for conditions not related to her employment. The Arbitrator believes that the evidence thus establishes that the Petitioner reached a point of maximum medical improvement as of the date of her FCE, and her entitlement to TTD ended at that time. She is entitled to TTD benefits from April 17, 2012 through January 30, 2013, and the Respondent is entitled to credit for nonoccupational benefits paid during that time.

With regards to the nature and extent of the injury, the Arbitrator makes the following conclusions of law:

As stated above, the Arbitrator finds the Petitioner reached a point of maximum medical improvement from her accidental injuries on January 30, 2013. She had ongoing symptoms and treatment from Dr. Vinje following her surgery, and still complained of symptoms when he last saw her on June 18, 2012. The Petitioner testified that she still has dorsal wrist pain from the thumb to the left forearm.

Based on the above, the Arbitrator finds that she has sustained an additional loss of use of the left hand to the extent of 10 % which, when combined with the loss found in the companion case, brings her disability to 25 % of the let hand.

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 up	☐ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

REX KIEFFER,

Petitioner,

vs. NO: 10 WC 048889

BEELMAN TRUCK COMPANY,

17IWCC0507

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the parties herein and notice given to all parties, the Commission, after considering the issues of accident, notice, medical, causal connection, temporary total disability, permanent disability, attorney's fees pursuant to §16, and penalties pursuant to §19(k) and §19(l), and being advised of the facts and law, modifies the Decision of the Arbitrator filed on November 10, 2016 as stated below and otherwise affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Procedural History

Arbitrator Lindsay issued a §19(b) Decision on January 31, 2013 finding that Petitioner sustained accidental injuries arising out of and in the course of his employment on March 26, 2010 and found in Petitioner's favor regarding the issues of notice and causal connection and awarded Petitioner temporary total disability benefits from March 26, 2010 through September 6, 2012, medical bills listed in Petitioner's trial exhibit and prospective medical benefits for a left shoulder MRI, vocational rehabilitation assessment and functional capacity evaluation (FCE) "if appropriate," (if the MRI is negative). Arbitrator Lindsay excluded the report of psychologist Steven Vincent and excluded his bills from the award and denied penalties finding Respondent's conduct at that time was not vexatious or unreasonable.

17IWCC0507

The Commission filed a Decision on September 17, 2013 (13 IWCC 0805) modifying the Arbitrator's Decision regarding Petitioner's average weekly wage (AWW) rate determining an AWW of $740.91 and regarding Petitioner's alleged inability to read and write, finding Petitioner's testimony was inconsistent with his education, work experience and other evidence. The Commission also answered Respondent's Special Interrogatories and affirmed the remainder of the Arbitrator's Decision.

The case last came before the Commission pursuant to the October 2, 2014 Order of the Circuit Court of The Seventh Judicial Circuit, Sangamon County which stated the appeal to the Circuit Court was premature. The court found it lacked jurisdiction since the Commission decision was not a final order having been remanded to the Arbitrator for further proceedings on the issue of vocational rehabilitation assessment pursuant to the holding in *Supreme Catering v. Ill. Workers' Comp. Comm'n*, 2012 IL App (1st) 111220WC, 976 N.E.2d 1047, 364 Ill. Dec. 484 (Ill. App. Ct. 1st Dist. Aug. 20, 2012). The matter was remanded back to the Commission to finalize the case.

Pursuant to the Court's instructions, and upon receipt of the record of proceedings in this matter, the Commission remanded this matter back to the Arbitrator assigned to the Springfield venue for disposition on January 28, 2016 and consistent with the Commission's prior Decision and Opinion on Review entered September 17, 2013.

Arbitrator Lee most recently presided over the Arbitration hearing on remand on two hearing dates, March 31, 2016 and September 26, 2016 and filed his Decision on November 10, 2016. In his Decision, Arbitrator Lee found that Respondent is entitled to credit under §8(j) and ordered Respondent to pay Petitioner $444.55 per week for a period of 200 weeks for injuries Petitioner sustained to the extent of 40% loss of use of the person as a whole as a result of the March 26, 2010 accident and Respondent is to receive a credit in the amount of $3,951.52 for the prior advance.

Both parties appealed Arbitrator Lee's Decision.

Findings of Fact and Conclusions of Law.

The Commission strikes those portions of the Arbitrator's decision regarding Petitioner's ability to read and write. The Commission's findings in its September 17, 2013 decision, quoted by the Arbitrator on page three, states in pertinent part "The Commission finds suspect Petitioner's testimony, and his wife's testimony, as to his inability to read or write...The Commission finds that while Petitioner testified to an inability to read or write, his educational and work experience strongly suggest otherwise." Petitioner was 42 years old at the time of the subject accident. Therefore, the Commission finds that testimony from Petitioner's grade school and high school teachers regarding his reading and writing skills is not reliable or relevant. Accordingly, on page four of the Arbitrator's decision, the Commission strikes the first full paragraph and subsequent second and third paragraphs in their entirety. The Commission also strikes a portion of Debbie Kieffer's testimony, the third sentence in paragraph four on page four, "She testified that Petitioner cannot read or write." On page five of the Arbitrator's decision, the Commission further strikes the fourth full paragraph in its entirety, beginning with "At Petitioner's request," and ending with "Dr. Fritz testified that it is possible that Petitioner could have manipulated his test scores."

17IWCC0507

On page six, in the second full paragraph, the Commission further strikes "(See Attachment A)" at the end of the sixth sentence because there are no attachments to the Arbitrator's decision and strikes the entire last two sentences in that paragraph.

The Commission finds that Petitioner is entitled to the cost of the vocational rehabilitation assessment performed by Ms. Delores Gonzalez pursuant to the Commission's prior Decision and Opinion on Review entered September 17, 2013.

The Commission vacates the Arbitrator's denial of penalties and finds Petitioner is entitled to §19(l) penalties for non-payment of benefits under §8(a) and §8(b) of the Act, in the amount of $10,000.00, the maximum allowed for failing to pay benefits pursuant to the Commission's prior Decision and Opinion on Review entered September 17, 2013.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed on November 10, 2016, 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 $444.55 per week for a period of 200 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 40% person as a whole. Respondent is to receive credit in the amount of $3,951.52 for the prior advancement of permanent partial disability.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the cost of the vocational rehabilitation assessment performed by Ms. Delores Gonzalez.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $10,000.00 for penalties under §19(l) of the Act.

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

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

17IWCC0507

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00, the maximum allowed. 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 2017
KWL/bsd
08/16/17
42

Kevin W. Lamborn

Thomas J. Tyrrell

Michael J. Brennan

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KIEFFER, REX
Employee/Petitioner

Case# **10WC048889**

BEELMAN TRUCK COMPANY
Employer/Respondent

17IWCC0507

On 11/10/2016, 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 0.53% 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:

1909 ACKERMAN LAW OFFICE
JAMES W ACKERMAN
1201 S 6TH ST
SPRINGFIELD, IL 62703

0332 LIVINGSTONE MUELLER ET AL
KENNETH BIMA
PO BOX 335
SPRINGFIELD, IL 62705

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

Rex Kieffer
Employee/Petitioner
v.
Beelman Truck Co.
Employer/Respondent

Case # 10 WC 48889
13 IWCC 0805

17IWCC0507

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 **Springfield**, on **3/31/2016 & 9/29/2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **3/26/10**, 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* causally related to the accident.

In the year preceding the injury, Petitioner earned $**29,309.02**; the average weekly wage was $**740.91**.

On the date of accident, Petitioner was **42** years of age, ***single*** with **1** dependent children.

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

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

Respondent shall be given a credit of **N/A** for TTD, **N/A** for TPD, **N/A** for maintenance, and $**3,951.52** for other benefits, for a total credit of $.

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

ORDER

Respondent is to pay Petitioner $444.55 per week for a period of 200 weeks as Petitioner sustained 40% loss of use of the person as a whole as a result of 3/26/2010 accident. Respondent is to receive a credit in the amount of $3,951.52 for the prior advancement of permanent partial disability.

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

11/4/16
Date

NOV 10 2016

The Arbitrator Finds the Following Facts:

This matter proceeded to arbitration on a 19(b) petition in front of Arbitrator Nancy Lindsay on 9/06/2012 and 12/05/2012. Arbitrator Lindsay found in favor of Petitioner on the issues of notice, accident, causal connection and ordered Respondent to pay temporary total disability benefits from March 26, 2010 – September 6, 2012. Arbitrator Lindsay also found Respondent responsible for medical bills listed in Petitioner's trial exhibit. Arbitrator Lindsay denied penalties and noted that Respondent's conduct had not been vexatious or unreasonable. Arbitrator Lindsay also agreed with Respondent and did not admit into evidence the deposition of psychologist Stephen Vincent.

Respondent appealed the arbitration decision to the Illinois Workers' Compensation Commission. The Illinois Workers' Compensation Commission rendered a decision on 9/17/2013 in which they affirmed the findings of Arbitrator Lindsay on the issues of notice, accident, causal connection, TTD benefits and medical benefits. The Illinois Workers' Compensation Commission modified Petitioner's average weekly wage and found an average weekly wage of $740.91. Lastly, the Illinois Workers' Compensation Commission reversed the Arbitrator's findings regarding Petitioner's ability to read and write and found that Petitioner's testimony regarding his inability to read and write was not credible. Specifically, the Commission found:

> **"The Commission finds suspect Petitioner's testimony, and his wife's testimony, as to his inability to read or write based upon: 1. His numerous prior employers – Horace Mann Insurance, Respondent, Lowe's, K-Mart, Simplex, Igor Amour Car, and farm owners; 2. His numerous and varying prior work duties as a maintenance worker, truck driver, sales clerk, delivery driver, assembly line worker, and farm hand; 3. His ability to pass the CDL vision and written test during 15 years as a truck driver; 4. His graduation from high school; and 5. The numerous health claim forms and patient in-take forms that clearly appear to have been completed by Petitioner based upon the similar hand writing shown in those forms, and the similar hand writing depicted in Petitioner's signature on his application for adjustment of claim . . . The Commission finds that while Petitioner testified to an inability to read or write, his educational and work experience strongly suggests otherwise." (RX1)**

Respondent appealed the decision of the Illinois Workers' Compensation Commission to the Circuit Court of Sangamon County. The Circuit Court found that the appeal was premature and remanded the case back to the arbitration level to finalize the case (PX2).

This matter then proceeded to arbitration to finalize all issues on 3/31/2016. Following trial testimony, proofs were kept open to secure the telephone records from Petitioner and witness Gene Boblitt. On 9/29/2016, the telephone records were admitted into evidence and proofs were closed.

Medical records from the Springfield Clinic indicate that Petitioner was seen on 12/22/2012 by Dr. Brett Wolters. On that date, Dr. Wolters diagnosed the Petitioner with adhesive capsulitis of his left shoulder. Petitioner continued to report pain. Dr. Wolters recommended continued conservative pain management with a home exercise program. On 8/12/2013, Petitioner saw Dr. Wolters' physician assistant and reported continued left shoulder pain. The physician assistance recommended an MRI and a functional capacity evaluation (RX8). A few weeks later, Petitioner was seen by Dr. David Pittman, on 8/21/2013 for a commercial driver's license (CDL) physical. Dr. Pittman recertified Petitioner for his commercial driver's license and noted **"He continues to have some mild limitations of his left shoulder with regard to reaching above the level of the shoulder. Dr. Wolters continues to work with him on this. He is presently not working. He has no problem driving,**

however, he tells me. He has adequate range of motion for those activities" (RX4). On 8/13/2015 Petitioner was seen by Midwest Occupational Health Associates for a Department of Transportation (DOT) physical. Petitioner was recertified for his DOT physical and it was noted that **Petitioner met the standards for the recertification and that his left shoulder had decreased range of motion but it did not affect the strength of his shoulder (RX9).**

Over Respondent's objection, Petitioner offered the testimony of Ellen Carter, Nancy Schrenk, Debbie Kieffer and Dr. Stephen Fritz to address Petitioner's ability to read and write. Respondent's objection is based on the defense of *res judicata*. Under the doctrine of *res judicata*, a final judgment by an adjudicative tribunal on the merits is conclusive as to the rights of the parties and their privies, and operates as an absolute bar to a subsequent action involving the same claim, demand or cause of action. In Donald Werries v. Industrial Commission, 114 Ill. 2d 43; 449 N.E. 2d 459, the Illinois Supreme Court specifically found that "A party cannot present only a portion of his case before the arbitrator and then subsequently supply the deficient portions by presenting additional evidence before the Industrial Commission." In reaching this decision, the Illinois Supreme Court stated that their finding is consistent with the Illinois Workers' Compensation Commission's position that an arbitrator must have all available evidence before her at the time of hearing in order to render a proper decision. There is no evidence to indicate that the above-mentioned witnesses were not available at the original 19(b) hearings. If Petitioner desired to secure testimony from Ellen Carter, Nancy Schrenk, Debbie Kieffer, and Psychologist Vincent, he had more than enough opportunity to do so prior to the 19(b) hearing. The Arbitrator notes Respondent's objection but allows this testimony.

Ms. Ellen Carter testified that in 1979 she worked as a special education aid for the Williamsville School District and worked with Petitioner as his tutor. Petitioner grew up in her neighborhood. She also tutored Petitioner at his home at the request of Petitioner's mother. Ms. Carter testified that Petitioner was in special education classes throughout high school. She would help Petitioner with tests by reading the test to him and then writing down Petitioner's answers. Ms. Carter testified that Petitioner graduated from Williamsville High School. He took special education classes in art, health education, English and general math. Petitioner passed regular classes in science, driver's education, and physical education.

Ms. Nancy Schrenk testified that she was a teacher at Williamsville High School in the 1980's and Petitioner was a student that she had in her classroom. Ms. Schrenk taught special education and worked with Petitioner for one year. Ms. Schrenk testified that Petitioner learned to read things like cat and dog and she suspected that Petitioner had dyslexia. Ms. Schrenk testified that Petitioner has great compensatory skills and a great personality.

Ms. Debbie Kieffer testified on behalf of her husband. She has been married to Petitioner since 2011. She testified that Petitioner cannot read or write. Ms. Kieffer testified that Petitioner continues to have problems with his shoulder.

Mr. Gene Boblitt testified that he has known Petitioner for 25 years and Petitioner is like a brother to him. Mr. Boblitt spends most of his day with Petitioner and helps him with his job search. Mr. Boblitt agreed that at the time of the original 19(b) hearing, he spent two days with Petitioner helping him with his job search (PX11).

Mr. Boblitt testified that he handwrote the additional job searches and they are true and accurate. Mr. Boblitt testified that regarding this job search **"I did it when we were doing it, sir. When we were doing it I wrote it down because if I wait two days later, I am not going to give you an honest answer. I mean, I have to do it while we are doing it."** Mr. Boblitt testified that he helped Petitioner look for about three jobs a day for

approximately 300 and some days. Mr. Boblitt testified that he would get the phone book out and start in the front of the book to look for occupations that Petitioner could do. Mr. Boblitt is not sure why they stopped at three job searches a day other than that is what Petitioner told him. He would fill out forms for Petitioner including forms from Midwest Occupational Health and for Petitioner's CDL. Mr. Boblitt testified that Petitioner is very handy, can think on his feet, is personable, and can read some words. Mr. Boblitt testified that Petitioner could work in some auto body jobs, in heating and AC positions, in maintenance positions and has plumbing skills. Mr. Boblitt testified that Petitioner can drive a tractor and a bobcat. Mr. Boblitt testified that he never stopped in on an employer to see if they had any openings. Mr. Boblitt testified that he never helped Petitioner apply for a job online.

Petitioner testified that he continues to have problems with his left shoulder which affects various activities that he performs throughout the day. Petitioner testified that the extent of his job search is calling three employers a day. Petitioner, with the help of Mr. Boblitt, goes through the phone book to determine who to call. Once Mr. Boblitt gives Petitioner the name of the employer and the number, he calls them and asks if they have any openings. Petitioner testified that a few would ask for a resume and he would take a resume to them. Petitioner cannot recall which employers he dropped his resume off and his job search list does not indicate it. **Petitioner testified that he was at the Springfield docket on 6/25/2015. Petitioner's job search log for that date indicates that he contacted Super Wash Car Wash, Tropical Rain and Robertson's Home Imperial. Petitioner testified that he met with Gene before they came to the Springfield docket and contacted these employers. Petitioner testified that these places are open at 6-7:00 a.m.**

Prior to the injury to his left shoulder, Petitioner worked for numerous places. Petitioner worked as a janitor for Memorial Medical Center from 1985-1989. Petitioner worked at Horace Mann Insurance Company doing plumbing, electrical, and maintenance work for seven years. Petitioner worked for Lowe's for five to six years. He worked for K-Mart for one to two years. Petitioner worked for a company called Simplex. Petitioner performed assembly line work for that company. Petitioner drove a truck for a company called Igor for six years. Petitioner worked for Greenview Landscaping doing landscaping work for two years. Petitioner worked for Villa Health Care Center in the maintenance department for three years. Petitioner has 15 years' experience driving a semi. Petitioner agrees that he can drive a truck and that he went to MOHA and passed a DOT physical and has a current CDL license.

Mr. Boblitt was recalled to testify regarding June 25, 2015. **Mr. Boblitt remembers being at the Springfield docket at 9:00 a.m. Mr. Boblitt testified that on the morning of June 25, 2015 he did not meet with Petitioner and contact employers but came straight to the Springfield docket. Mr. Boblitt was unsure if Petitioner actually looked for work on 6/25/2015 or if that was another day.**

At Petitioner's request, Petitioner was seen by clinical psychologist Dr. Stephen Fritz on 11//04/2013 and 11/12/2013 to assess Petitioner's psychological functioning as it pertains to his cognitive and academic abilities. Petitioner was sent to Dr. Fritz for the purpose of addressing Petitioner's ability to read and write. Dr. Fritz administered several tests on Petitioner which he interpreted as demonstrating that Petitioner was functioning at or near the kindergarten level. Dr. Fritz testified that this would not be consistent with Petitioner's job history and the ability to drive a semi. Dr. Fritz testified that it is possible that Petitioner could have manipulated his test scores (PX14).

At Respondent's request, Ms. Delores Gonzalez performed a vocational rehabilitation evaluation on Petitioner after meeting with Petitioner on 12/20/2014. As part of her evaluation, Ms. Gonzalez relied on the reports of Dr. Fritz and Dr. Vincent (Arbitrator Lindsay rejected Dr. Vincent's report into evidence.) The Arbitrator notes

that Ms. Gonzalez did not review the evidence deposition of Dr. Wolters in which he addressed maximum medical improvement and Petitioner's permanent restrictions. It was Ms. Gonzalez's understanding that Petitioner was restricted from all work. Based on this understanding, Petitioner's low IQ, and his inability to read and write, Ms. Gonzalez opined that Petitioner is not employable in the open labor market (PX13).

Ms. Karen Kane-Thaler testified on behalf of the Respondent. Ms. Kane-Thaler has worked as a vocational consultant for the past 26 years and is a certified rehabilitation counselor. She is also a licensed professional counselor through the State of Illinois. She performed labor market surveys on 1/24/2015 and 12/06/2015. As part of performing the labor market surveys, Ms. Kane-Thaler reviewed the evidence deposition of Dr. Wolters in which he referenced Petitioner's permanent restrictions. Ms. Kane-Thaler reviewed Petitioner's prior trial testimony in which he indicated that he could not read and write. Ms. Kane-Thaler also reviewed Petitioner's prior vocational background/employment. It was Ms. Kane-Thaler's opinion that Petitioner would be able to seek, accept and be hired and maintain employment in a stable labor market such as those she listed in her labor market surveys. Ms. Kane-Thaler was aware of Petitioner's issues with reading and writing. However, based on Petitioner's work history, it is clear that Petitioner has been able to maintain sustained employment prior to the work injury.

Petitioner and Mr. Boblitt's phone records were admitted into evidence. Mr. Boblitt's phone records indicate that he did not make any job search calls using his phone. The Arbitrator note that Petitioner's phone records were inconsistent with the trial testimony of Petitioner and Mr. Boblitt. **Petitioner did not call three prospective employers each day from 12/30/2014 to 4/01/2016 as noted in PX23 and the trial testimony. Contrary to PX23 and Petitioner and Mr. Boblitt's testimony, Petitioner did not look for work in over 300 days. The phone records indicate that from 12/30/2014 – 4/01/2016, Petitioner only contacted employers on 21 occasions for a total of two hours and 27 minutes (See Attachment A). Also, despite Petitioner testimony about looking for work on 6/25/2016, Petitioner did not call employers on that date. The Arbitrator, in reviewing Petitioner's phone records also notes that he contacted telephone number 217-553-1631 during this same period over 541 times representing 1 hour and 45 minutes. A search of this number reveals that it is an escort service located in Springfield, Illinois (See attachment B).**

Therefore, the Arbitrator finds:

The Arbitrator notes that Petitioner is 49 years old and right hand dominant. As a result of the 3/26/2010 work accident, Petitioner sustained permanent restrictions to his non-dominant left upper extremity. Specifically, in his evidence deposition dated 5/18/2012, Dr. Wolters opined that Petitioner had reached maximum medical improvement in July of 2011. Regarding permanent restrictions, Dr. Wolters testified:

Q: What limitations would you put on him?
A: No overhead work, and then as far as lifting, his overhead lifting would be very limited because he can't get his arm over his head. So a pound restriction is more limited by his ability to lift overhead than anything else.
Q: Alright.
A: As far as lifting at the side, it would be whatever he could tolerate, because that would not be affected. (19(b) hearing PX13)

The Arbitrator also notes Petitioner's work history prior to the accident of 3/26/2010. From 1985 – 1989, Petitioner worked as a janitor for Memorial Medical Center. From 1989 – 1991, Petitioner worked as a maintenance worker for Villa Health Care Center. From 1991 – 1993, Petitioner worked as a landscape laborer

for Greenview Landscaping. From 1993 – 1996, Petitioner drove a dump truck for P.H. Broughton. From 1994 –2001, Petitioner worked as a maintenance technician for Horace Mann. From 1996 – 1999, Petitioner worked at K-Mart. From 1999 – 2004, Petitioner drove a delivery truck for Lowe's. From 2004 – 2007, Petitioner drove an armored car and transported lottery tickets for Igor Armored Car Company. From 2008 – 2009, Petitioner drove a truck for Curry Trucking. From 2009 – 2010, Petitioner drove a truck for Respondent. The Arbitrator also notes that Petitioner has a current DOT physical and CDL license. While the extent of Petitioner's ability to read and write is at issue, for 25 years prior to the work accident, Petitioner demonstrated the ability to maintain stable employment.

The Arbitrator finds that Petitioner did not perform a good faith job search. Petitioner's actions were inconsistent with someone who is interested in securing employment. For the period of 12/30/2014 – 4/01/2016, or one year and three months, Petitioner spent two hours and 27 minutes calling prospective employers!

Petitioner and his friend's credibility was significantly compromised based on the phone records. Despite testifying under oath about a job search log (PX11), and to making three employer contacts a day for over 300 days, the phone records reveal that Petitioner called employers only on 21 days over the 1 year and three month period. Petitioner's testimony about contacting three employers during the morning of 6/25/2015 prior to appearing at the Springfield docket was also contradicted by the phone records.

The Arbitrator finds that Petitioner's credibility is significantly compromised based on these inconsistencies.

Therefore, based on Petitioner's lack of a good faith job search and lack of credibility in this regard, the Arbitrator finds that Petitioner is not entitled to additional lost time benefits.

For the reasons stated above, the Arbitrator finds that the Petitioner is employable in a stable labor market such as those jobs noted in the labor market surveys. As such, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 40% loss of use of the person as a whole.

Pursuant to the fee schedule, Respondent is responsible for payment for the related medical bills.

Petitioner's claim for penalties is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF)
SPRINGFIELD

☒ 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

Mark L. Marinelli,
Petitioner,

vs.

NO: 14WC 2589

City of Springfield,
Respondent.

17IWCC0508

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, medical, temporary total disability, maintenance, 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.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 10, 2016 is hereby affirmed and adopted.

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

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

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

DATED: AUG 18 2017
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MJB/jrc
052

Michael J. Brennan

Kevin W. Lamborn

Thomas J. Tyrrell

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

MARINELLI, MARK
Employee/Petitioner

Case# **14WC002589**

CITY OF SPRINGFIELD
Employer/Respondent

17IWCC0508

On 11/10/2016, 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 0.53% 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
CHARLES H DELANO IV
1 S E OLD STATE CAPITOL PLZ
SPRINGFIELD, IL 62705

0332 LIVINGSTONE MUELLER ET AL
L ROBERT MUELLER
620 E EDWARDS PO BOX 335
SPRINGFIELD, IL 62705

STATE OF ILLINOIS)
)SS.
COUNTY OF Springfield)

- [ ] 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)

Mark Marinelli
Employee/Petitioner

v.

City of Springfield
Employer/Respondent

Case # 14 WC 2589

Consolidated cases: N/A

17IWCC0508

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 **Springfield**, on **9/26/16**. 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. [ ] Is Petitioner entitled to any prospective medical care?
L. [x] What temporary benefits are in dispute?
[ ] TPD [x] Maintenance [ ] TTD
M. [ ] Should penalties or fees be imposed upon Respondent?
N. [ ] Is Respondent due any credit?
O. [x] Other **Has Respondent fulfilled its responsibility with regard to providing vocational services?**

FINDINGS

On the date of accident, **11/01/13**, 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.

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

In the year preceding the alleged date of injury, Petitioner earned **$69,084.60**; the average weekly wage was **$1,328.55**.

On the alleged date of accident, Petitioner was **41** 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 for all TTD and maintenance paid.

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

ORDER

The Arbitrator finds no accident or causal connection. Therefore, the claim for compensation is denied.

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

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

Edward Lee
Signature of Arbitrator

10/29/16
Date

ICArbDec19(b)

NOV 10 2016

With regard to Accident (C) and Causal Relationship (F), the Arbitrator finds the following:

The Petitioner testified that he was a Springfield Police officer starting on March 20, 2006. As a patrol officer, he drove a squad car. He wrote reports, citations and stop sheets after a traffic stop. He would type on the computer and he would arrest people. Petitioner noted he would write reports typing on the computer in the squad car. Every time you would pull somebody over or make an arrest, you would have to type on the computer to check if the person is valid or if there were outstanding warrants. Petitioner estimated that he would spend 30 to 40 minutes typing on his computer in his vehicle per shift. Petitioner testified that on April 28, 2013 he noticed a problem with his hands. This involved numbness and tingling. He described tightness in his hands and a numbness feeling in his fingertips. Petitioner indicated that his symptoms were first experienced driving back to Springfield in a car on April 28, 2013, planning to go to work that night. He called in and told someone at the desk that he was not going to be able to make it. Petitioner indicated he was having some dizziness and nausea at that time. He indicated he was not sure what was going on. He did not know if the person he talked to said the flu or he said the flu but flu was put down as the reason he was not going to be at work.

According to the medical records, Petitioner went to Memorial Medical Center on April 30, 2013. That was his first treatment. The ExpressCare physician notes reflect that the patient has been nauseated for three days. Petitioner stated that he felt like he was drunk. He could not give a clear description of what his main complaint was. He was very emotional. Petitioner was not complaining of any pain, swelling, or tingling. The emergency room record indicates under review of symptoms that additional review of all other symptoms was negative. With the physical examination, the neurological portion noted no focal neurological deficit observed (RX8). Petitioner was seen by nurse practitioner, Tammy Bartolomucci, at Dr. Hanson's office on 5/01/13. By way of history, he noted that last Thursday he took a Claritin D. After that when driving his wife's van with his hand elevated, it started to go to sleep. He did sleep well that night. Friday he went golfing and felt tired. Saturday he felt hungover without a headache. Petitioner was complaining of his hands being numb (PX18). Petitioner was seen the same day at Dr. Valenti's office by Melissa Partridge. Petitioner was complaining of constant sharp achy pain in his left hand and numbness and tingling in both hands for six days. At rest, petitioner noted his hands feel like they fall asleep. He rated the discomfort at 8/10 but getting worse. The working diagnosis was cervical radiculopathy at that time and Petitioner underwent chiropractic treatment for a few days (PX6). On 5/10/13 Petitioner saw Dr. Narla and gave a history of numbness in both hands for about 10 days. This usually started on the right side and spread to the left. Petitioner indicated that he gets crampiness when he writes reports. The doctor noted the symptoms are mostly confined to the palm and all the fingers. The doctor's impression was bilateral tingling and numbness starting on the right and then starting on the left in the last 10 days. The doctor thought this likely to be bilateral carpal tunnel (PX3).

When Petitioner saw Dr. Wottowa for the first time on 6/20/13, he gave a history of bilateral hand numbness and tightness. He has had symptoms since April 28. There was no injury or trauma. He was driving and started noticing numbness and tingling in both of his hands. Since then, he has had numbness, tingling and tightness in both hands and tightness up in the forearm region. Petitioner first saw Dr. Mackinnon on 11/04/13. Although the doctor's hand written notes indicate April 28, 2013 as the onset of symptoms, the letter to Dr. Wottowa dated 11/08/13 erroneously says August 28. This indicates that when he was driving back from his mother-in-law's house he developed a rather sudden onset of numbness in his hands, with tightness. That persisted thereafter. It was at that time that Dr. Mackinnon mentioned muscle imbalance and thoracic outlet syndrome.

Petitioner was seen by Dr. Robert Thompson on 1/22/14. At that time, the history was that there was an onset of symptoms in April of 2013. It was described as a spontaneous onset of pain, numbness and tingling in the hands. The doctor's note indicates that this occurred at a time that Petitioner was shooting, but it persisted after that time. Petitioner's problems were aggravated when he was driving or riding. The history was that part of Petitioner's work involved lengthy periods of time writing reports in a car where he is crouched over a writing

pad or keyboard. In a noted dated 3/13/14, Dr. Thompson indicated that the diagnosis of neurogenic thoracic outlet compression syndrome was the result of a work injury from many years of long-distance driving, sitting in a car and long periods of typing and writing (PX8). Petitioner was also seen by Dr. William Warren at the request of Respondent. The examination took place on 3/26/14. The history was that Petitioner was driving a minivan and developed progressive numbness in both hands on April 28, 2013. Dr. Warren received a history that Petitioner filled out reports and worked the computer keyboard in his patrol car. Dr. Warren felt that the pain and numbness were aggravated by driving, prolonged writing or using a keyboard, especially when at or above waist level. Dr. Warren felt that Petitioner had a pre-existing condition which was aggravated by the job activities including use of the computer in the squad car and writing reports on the steering wheel (PX30).

Petitioner noted on the employee accident report he signed that the cause of his problems was slouching while writing reports and driving (RX12). Dr. DeBord evaluated Petitioner in the course of his pension fund claim. The doctor noted that Petitioner's condition is an anatomical anomaly that becomes symptomatic under job related stressors. He noted the plethora of duties of a police officer such as repetitive typing of reports, sometimes in awkward positions, in a patrol car, using the car computer, sudden motions and strains of apprehending criminals and multiple sessions shooting firearms (PX32).

Dr. Warach also evaluated Petitioner in his pension fund claim. He noted that Petitioner's work involved extensive writing and use of the computer which may possibly predispose him to thoracic outlet syndrome. He indicated that most likely his body habitus predisposed to thoracic outlet syndrome (PX23).

Dr. Mehra also evaluated Petitioner with respect to his pension fund claim. The doctor felt that Petitioner's present symptoms were the result of his duties as a police officer. He mentioned grabbing people and repetitive hand movements. The doctor also mentioned a lot of arm and hand motor activity.

The Petitioner first saw Dr. Claude Fortin on 5/05/16. The history at that time was a sudden onset of bilateral distal arm pain and numbness on 4/28/13 driving a squad car working as a police officer. The doctor's plan notes sudden onset of bilateral and persistent arm pain with uncertain etiology (PX33).

The Arbitrator notes that Petitioner testified that on April 28, 2013, he first noticed symptoms in his hands driving back to Springfield planning to go to work that night. This would have been a Sunday. He did not seek medical attention the following day, but went to the emergency room at Memorial Medical Center on April 30, 2013. He did not complain of any pain, swelling or tingling. He mentioned being nauseated for three days. When he went to his personal doctor's office the following day, the history was that last Thursday, which would be April 25, he took a Claritin D. After that, he was driving his wife's van with his hand elevated and it started to go to sleep. When he went to Dr. Valenti's office the same day, he complained of pain in the left hand and numbness and tingling in both hands for six days. When he saw Dr. Narla on 5/10/13, the doctor noted that he had bilateral tingling and numbness which started on the right and then went to the left in the last 10 days. When he saw Dr. Wottowa on 6/20/13, the symptoms were said to start on April 28 with numbness and tingling in both hands. When Petitioner saw Dr. Mackinnon on 11/04/13, the onset of symptoms was again April 28, 2013, driving back from his mother-in-law's house with a sudden onset of numbness and tightness. Petitioner saw Dr. Thompson on 1/22/14 with a history of a spontaneous onset of pain, numbness and tingling in the hands in April of 2013. When seeing the Respondent's IME doctor, Dr. Warren, on 3/26/14, Petitioner noted he developed progressive numbness in both hands driving a minivan on April 28, 2013. The history to Dr. Fortin on 5/05/16 is a sudden onset of bilateral distal arm pain and numbness on 4/28/13 driving a squad car working as a police officer. The Arbitrator notes that there are many inconsistencies with regard to when exactly the symptoms began and what Petitioner was doing. The Arbitrator notes that Petitioner even indicated to Dr. Narla that he got crampiness when he wrote reports. However, the most consistent history was that there a spontaneous onset of symptoms which occurred when Petitioner was not working.

The Arbitrator notes the opinion from Dr. Thompson that the problems were the result of a work injury from many years of long distance driving, sitting in a car and the long periods of typing and writing. However, Petitioner testified that he would spend 30 to 40 minutes typing on his computer in his vehicle per shift. There is no evidence of long distance driving as Petitioner was a police officer in the city of Springfield. Dr. Warren noted prolonged driving or using a keyboard. This does not appear to be the case based upon Petitioner's testimony. Further, the Arbitrator notes the medical records from Dr. Fortin indicating that Petitioner had a sudden onset of bilateral and persistent arm pain with uncertain etiology. The Arbitrator notes that the doctors' opinions with regard to a causal relationship between Petitioner's work activities and his thoracic outlet syndrome and symptomatology are not supported by the evidence in the record with regard to what Petitioner did in the course of his employment as a police officer with Respondent. Based upon the inconsistencies regarding the accident and with regard to Petitioner's job activities, as well as the fact Petitioner's initial symptoms began when he was not working, the Arbitrator finds that the Petitioner has failed to prove that he sustained repetitive trauma in the course of his employment with Respondent which caused the development of thoracic outlet syndrome, or any other condition. Therefore, the claim for compensation is denied.

STATE OF ILLINOIS)
) SS.
COUNTY OF DUPAGE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Linda Brinkman,

Petitioner,

vs.

NO. 15 WC 05920

17IWCC0509

Paramount Residential Mortgage Group,

Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 17, 2016 is hereby affirmed and adopted.

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

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

17IWCC0509

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 18 2017
SJM/sj
o-6/29/17
44

Stephen J. Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BRINKMAN, LINDA
Employee/Petitioner

Case# **15WC005920**

PARAMOUNT RESIDENTIAL MORTGAGE GROUP
Employer/Respondent

17IWCC0509

On 10/17/2016, 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 0.49% 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:

2277 MARK G PATRICOSKI PC
1755 S NAPERVILLE RD
SUITE 206
WHEATON, IL 60189

2837 LAW OFFICES JOSEPH MARCINIAK
BRENT W HALBLEIB
TWO N LASALLE ST SUITE 2510
CHICAGO, IL 60602

17IWCC0509

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

Linda Brinkman
Employee/Petitioner

v.

Paramount Residential Mortgage Group
Employer/Respondent

Case # **15** WC **5920**

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 **Wheaton**, on **August 29, 2016**. 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 January 31, 2015, Respondent *was* operating under and subject to the provisions of the Act conferring jurisdiction in Illinois.

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 an average weekly wage of $1,653.03.

On the date of accident, Petitioner was 66 years of age, *married* 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 (i.e., mileage expenses), for a total credit of $0.

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

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that she sustained a compensable accident on December 31, 2010 as claimed.

Temporary Total Disability Benefits

Respondent shall pay Petitioner temporary total disability benefits of $1,102.02/week for 2 & 5/7th weeks, commencing February 1, 2015 through February 19, 2015, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from February 1, 2015 through August 29, 2016, 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 medical providers for the bills submitted into evidence as provided in Sections 8(a) and 8.2 of the Act.

Permanent Partial Disability: Schedule Injury

As explained in the Arbitration Decision Addendum, Respondent shall pay Petitioner permanent partial disability benefits of $735.37/week for 75.25 weeks, because the injuries sustained caused the 35% loss of the left leg (hip), 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 14, 2016
Date

OCT 17 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Linda Brinkman
Employee/Petitioner

v.

Paramount Residential Mortgage Group
Employer/Respondent

Case # **15** WC **5920**

Consolidated cases: **N/A**

FINDINGS OF FACT

The issues in dispute at this hearing include accident, Respondent's liability for certain unpaid medical bills, Petitioner's entitlement to a period of temporary total disability benefits commencing on February 1, 2015 through February 19, 2015 as well as the nature and extent of the injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Linda Brinkman (Petitioner) worked for the Paramount Residential Mortgage Group (Respondent) on January 31, 2015 as a Conventional Mortgage Underwriter. She testified that her responsibilities including making credit decisions on credit-worthiness of borrowers to receive mortgage loans for residential properties that they wished to own or refinance. The mortgage review process could take from 90 minutes to four or five hours. Petitioner had worked for Respondent for about five months on the claimed date of accident, but had worked in the mortgage business for over 30 years.

January 31, 2015

Petitioner testified that she received the email mandate from corporate headquarters that employees would be required to work that weekend to underwrite a minimum of four files to be completed before Monday morning. She explained that this work was not optional. See PX2. The January 27, 2015 email from Herb Lewis (Mr. Lewis) forwarded an email from Robert Holliday (Mr. Holliday) with a subject entitled "Mandatory OT this weekend[.]" *Id.* The email states in pertinent part that "As we are all aware, it is getting very busy and will only get busier in the coming weeks and months. In an effort to try and stay ahead of the curve, I am going to be notifying all uw's tomorrow, that each underwriter must complete 4 files this weekend. When I say completed, it means in the system and not Monday when [the underwriters] come in to work, otherwise that defeats the purpose. This isn't an option[.]" *Id.*

Petitioner testified that she went to the office building on Saturday and completed four files as required and finished working in the office at approximately 6:00 p.m. On cross examination, Petitioner testified that other underwriter co-workers were also mandated to do this work, but none were at the office on Saturday. Petitioner testified that the work needed to be done in the office and she worked from approximately 11:30 a.m. to 6:00 p.m.

[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.

Petitioner testified that she was taking her completed files home because she had to complete worksheets relating to the appropriateness of the files. Petitioner testified that it was getting very dark and it was going to snow. While leaving the office Petitioner testified that she was carrying her backpack and underwriting manuals (MRIs) from Freddie Mac and Fannie Mae, which are the rules and regulations. Petitioner also testified that she was carrying files and/or worksheets in her backpack as well as in her hands. She explained that she was carrying about 8-10 pounds of materials, measuring about the size of two large phone books, and she used both of her hands to carry these materials.

At the hearing, the parties stipulated that the location of Petitioner's fall was in a common area that was not owned or controlled by Respondent. Respondent offered into evidence a lease in place at the time of the incident between Respondent and the building owner. RX1. The lease shows that Respondent did not own the building, but was rather a tenant. *Id.* A number of clauses in the lease delineate the rights and obligations of the landlord and tenant, including the responsibility for maintenance of the various spaces in the building. *Id.* The landlord, not Respondent, was responsible for maintenance of the building's elevator. *Id.*

Notwithstanding, Petitioner testified that the building was closed and not open to the general public on Saturday. She also testified that no one else was in the building at the time of her fall. Petitioner explained that she was only able to control the lights in her suite; she could not control the lights in the lobby. On cross examination, Petitioner testified that there are other businesses in the office building throughout the building's four floors as well as other businesses with suites on the third floor. Petitioner acknowledged that she could walk into the building without a key during the week.

When leaving her office, Petitioner testified that she entered the elevator on the third floor where her office was located. The elevator took Petitioner down to the lobby level and, as she was stepping forward out of the elevator, she testified that she felt like something caught her foot. Petitioner testified that the lighting in the lobby was very dim, almost dark, and it was already past sundown and there was no light coming in from the outside. She testified that she took one step out with one foot which hit the floor of the lobby because the elevator had gone some inches further down. Then Petitioner's other foot was caught on the carpet and it propelled her forward causing her to hit the opposite wall of the elevator bank. Petitioner explained that she realized that there was a height difference between the elevator and the lobby floor after the incident. Petitioner explained that her glasses fell off and broke, her keys fell down, and she hit the left side of her head against the other side of the wall. She dropped her work materials and fell to the ground. Petitioner testified that she was wearing tennis shoes at the time and realized that there was a height difference between the elevator and the lobby floor after the incident. On cross examination, Petitioner acknowledged that the elevator was lit on the inside.

Petitioner testified that she touched her head to see if she was bleeding, which she was not. She explained that she was very scared, but she composed herself and tried to get up, but started screaming from the pain and could not do so. She then reached for her cell phone and called her husband for help. Petitioner's residence is about six miles from the office building. Petitioner did not call 911. Her husband arrived 15-20 minutes later and she got herself to the entrance to let him inside. Petitioner's husband called 911 and the paramedics arrived who took her to Edwards Hospital. Petitioner testified that she had no prior left hip injury before her fall at work.

Medical Treatment

The Edward Hospital emergency room records reflect that Petitioner presented on January 31, 2015 after a fall when she hit her left hip and left side of her head. PX4. Petitioner underwent x-rays, which revealed a comminuted intratrochanteric fracture. *Id.*

The following morning on February 1, 2015, Petitioner underwent a left femur intramedullary fixation surgery performed by Dr. Andrew Kim (Dr. Kim). *Id.* The surgery required instrumentation including throchanteric nails and various screws. *Id.* Petitioner remained hospitalized for several days and was released on February 5, 2015 with instructions to follow up with post-operatively. *Id.* Petitioner explained that she understood that she had a broken hip and the surgery required insertion of a titanium rod into her left leg bone, another supporting rod into her hip, and another one into knee.

Petitioner testified that she then went into rehabilitation at the hospital followed by home rehabilitation/physical therapy. The medical records reflect that Petitioner underwent inpatient rehabilitation beginning on February 6, 2015 at Girling Health Care through February 18, 2015. PX6. Petitioner then underwent outpatient physical therapy at Lisle Physical Therapy beginning on March 17, 2015 two-to-three times per week for four weeks as ordered by Dr. Kim. PX5.

Petitioner testified that she was off work for 20 days. She did not receive workers' compensation benefits during this period of time, and her medical bills have not been paid. Petitioner testified that she returned to work and her husband initially drove her to work for about four weeks. She also had a walker for about five weeks and her husband would help her go into her office and then her co-workers would assist her to get around the office.

Additional Information

Regarding her current condition, Petitioner testified that she has less range of motion in her left leg compared to her right leg as well as weakness in her left leg compared to the right leg. She testified that she cannot stay in one position for long periods of time. At night, Petitioner has to shift positions quite a bit to prevent her leg and knee from locking. Petitioner also explained that her pain vacillates from time to time depending on increased or decreased use, changes in weather, etc. Petitioner testified that she shifts every 15-20 minutes, but sometimes after a little longer period of time. She also testified that occasionally she somewhat limps due to fatigue as well as cramping and aching in her leg. Petitioner further testified that she no longer wears heeled shoes.

Petitioner worked for Respondent until the end of April of 2015 and she was using a cane for a good part of the time. Petitioner then went to work for another mortgage group performing the same types of duties as she was while she worked for Respondent.

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 the hearing as follows:

In support of the Arbitrator's decision relating to Issue (C), whether Petitioner sustained an accident that arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

An employee's injury is compensable under the Act only if it arises out of and in the course of the employment. 820 ILCS 305/2 (LEXIS 2011). The "in the course of employment" element refers to "[i]njuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing his duties, and while a claimant is at work...." *Metropolitan Water Reclamation District of Greater Chicago v. IWCC*, 407 Ill. App. 3d 1010, 1013-14 (1st Dist. 2011). Additionally, Petitioner must establish the "'arising out of' component [which] refers to the origin or cause of the claimant's injury and requires that the risk be connected with, or incidental to, the employment so as to create a causal connection between the employment and the accidental injury." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14 (*citing Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d 52, 58 (1989)). A claimant must prove both elements were present (i.e., that an injury arose out of and occurred in the course of his employment) to establish that her injury is compensable. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006).

The record establishes that Petitioner's fall at work on January 31, 2015 occurred in the course of her employment. Petitioner went to the office pursuant to a direct instruction from Mr. Holliday, a member of Respondent's management team, to complete four files over that weekend. When Petitioner was leaving Respondent's third floor office via elevator to reach the lobby and exit the building, she was carrying approximately two phone books' worth of materials necessary to comply with Mr. Holliday's instruction that four files be completed.

The record also establishes that Petitioner's incident at work arose out of her employment with Respondent. 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 h[er] employment." *Metropolitan Water Reclamation District*, 407 Ill. App. 3d at 1013-14. That is, a claimant must demonstrate that the risk of injury was peculiar to or increased by her 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." 407 Ill. App. 3d at 1014 (*citations* omitted).

In this case, Petitioner was attempting to exit an elevator into a poorly lit elevator bank on the lobby level while carrying approximately two phone books' worth of work materials as well as a backpack. Petitioner's testimony reveals that the only reason she went to the office on the Saturday in question was to comply with Respondent's mandatory overtime instruction. Indeed, Mr. Holliday's email specified that four files were to be completed and he added, "[w]hen I say completed, it means in the system and not Monday when [the underwriters] come in to work, otherwise that defeats the purpose[, and t]his isn't an option[.]" PX2. Petitioner testified that the building was generally open to the public during the week, but it was locked on the weekend such that after her fall she nonetheless had to traverse to the locked entrance to let her husband into the building. No evidence was presented that the general public was allowed in the area in which Petitioner was injured. Indeed, it appears that

only Petitioner was exposed to any risk related to the uneven landing between the elevator and lobby floor on that particular Saturday.

In addition, while causal connection is not in dispute, the Arbitrator notes that the medical records reflect that Petitioner received emergency care immediately after her injury and that she continued to receive medical treatment to her left hip only as a result of her fall at work. No evidence was offered to controvert the medical records establishing that Petitioner's left hip condition stemmed solely from that fall.

Based on all of the foregoing, the Arbitrator finds that Petitioner has established that she sustained a compensable injury at work on January 31, 2015 as claimed.

In support of the Arbitrator's decision relating to Issue (J), whether the medical services that were provided to Petitioner were reasonable and necessary, whether Respondent has paid all appropriate charges for all reasonable and necessary medical services, the Arbitrator finds the following:

"Under section 8(a) of the Act (820 ILCS 305/8(a) (West 2006)), a claimant is entitled to recover reasonable medical expenses, the incurrence of which are causally related to an accident arising out of and in the scope of her employment and which are necessary to diagnose, relieve, or cure the effects of the claimant's injury." *Absolute Cleaning/SVMBL v. Ill. Workers' Compensation Comm'n*, 409 Ill. App. 3d 463, 470 (4th Dist. 2011) (citing *University of Illinois v. Industrial Comm'n*, 232 Ill. App. 3d 154, 164 (1st Dist. 1992)).

As explained more fully above, the Arbitrator finds that Petitioner has established that she sustained a compensable injury to her left hip. The outstanding medical bills submitted into evidence are for services related to Petitioner's left hip condition for reasonable and necessary medical treatment to alleviate Petitioner of the effects of her injury at work through her return to full duty work. Thus, the Arbitrator finds that Petitioner has established that the medical bills for such services were incurred as a result of reasonable and necessary medical care to alleviate her of the effects of a causally related injury at work and awards payment of these bills pursuant to 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:

In light of the accident and causal connection analyses above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the period beginning February 1, 2015 through February 19, 2015.

"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 (3rd Dist. 2014); *Matuszcak v. Ill. Workers' Comp. Comm'n*, 2014 IL App (2d) 130532 (2nd Dist. 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 he did not work, but also that he was unable to work. *Gallentine*, 201 Ill. App. 3d at 887; *see also City of Granite City v. Industrial Comm'n*, 279 Ill. App. 3d 1087, 1090 (5th Dist. 1996).

Petitioner's testimony and the medical records reflect that she was under medical treatment and was incapacitated as a result of the effects of her injury at work such that she was placed off work or on light duty restrictions related to her left hip condition during the claimed period of temporary total disability. Based on the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed.

In support of the Arbitrator's decision relating to Issue (L), 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 the hearing, the Arbitrator addresses the factors delineated in the Act for determining permanent partial disability.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. Thus, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time Conventional Mortgage Underwriter at the time of her accident. This evidence is uncontroverted. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 66 years old at the time of the accident. This fact is stipulated by the parties. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), the future earning capacity of the employee, the Arbitrator notes that there was no evidence of any diminishment in Petitioner's future earnings capacity as a result of her accident. Thus, the Arbitrator assigns significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Petitioner underwent an emergency left femur intramedullary fixation surgery for her comminuted intratrochanteric fracture requiring instrumentation followed by hospitalization for several days. Thereafter, Petitioner was released to inpatient rehabilitation followed by a course of outpatient physical therapy. Petitioner testified about her ongoing pain and difficulties including the need to often shift her weight, decreased range of motion, weakness in the left leg, weather sensitivity, and difficulty sleeping. Petitioner's testimony regarding her ongoing symptoms is uncontroverted, but also consistent with the medical records including her extensive rehabilitation and physical therapy records. Petitioner's testimony regarding her ongoing condition and the medical records documenting her treatment are also uncontroverted by any medical opinion. Based on the foregoing, the Arbitrator finds Petitioner's testimony to be credible and, thus, the Arbitrator assigns significant weight to this factor.

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 has established permanent partial disability to the extent of 35% loss of use of the left leg (hip) pursuant to §8(e) of the Act.

STATE OF ILLINOIS)
) SS.
COUNTY OF MADISON)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Denise DeGarmo,

Petitioner,

vs.

NO: 16WC 17193

17IWCC0510

Southern Illinois University Edwardsville

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19b having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of accident, temporary total disability, causal connection, medical expenses, prospective medical care, and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 1, 2016 is hereby affirmed and adopted.

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

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

DATED: AUG 18 2017
SJM/sj
o-8/3/17
44

Stephen J. Mathis

Deborah L. Simpson

David L. Gore

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b)/8(a) ARBITRATOR DECISION

DEGARMO, DENISE
Employee/Petitioner

Case# **16WC017193**

17IWCC0510

SOUTHERN ILLINOIS UNIVERSITY-EDWARDSVILLE
Employer/Respondent

On 12/1/2016, 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 0.61% 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:

4493 GOLDENBERG, HELLER, ANTOGNOLI
THOMAS J LECH
2227 S STATE ROUTE 157
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0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 1 - 2016

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

17IWCC0510

STATE OF ILLINOIS)
)SS.
COUNTY OF **MADISON**)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)/8(a)

DENISE DEGARMO
Employee/Petitioner

v.

SOUTHERN ILLINOIS UNIVERSITY - EDWARDSVILLE
Employer/Respondent

Case # **16** WC **17193**

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 **Paul Cellini**, Arbitrator of the Commission, in the city of **Collinsville**, on **July 20, 2016**. 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, **March 21, 2016**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$92,143.00**; the average weekly wage was **$1,771.98**.

On the date of accident, Petitioner was **60** 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**.

ORDER

The Arbitrator finds that the Petitioner has failed to prove an increased risk of injury, and therefore has failed to prove she sustained an accidental injury arising out of her employment with the Respondent on March 21, 2016.

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

November 29, 2016
Date

ICArbDec19(b)

DEC 1 - 2016

STATEMENT OF FACTS

The Petitioner worked as an associate professor at the Respondent's campus in Edwardsville, Illinois. On 3/21/16, the Petitioner had been teaching a class at 3406 Peck Hall. She had been teaching a class in Room 3406 of Peck Hall, and her car had been parked in Lot A, or the "Green Lot". The Petitioner testified that this lot was the one closest to most of the campus academic buildings. She also testified that an individual must either have a specific tag hanging in the car to park there, or must use a parking meter. She testified that the Respondent maintains the lot. Asked if the lot is where faculty members are directed to park, the Petitioner testified: "That is one lot that faculty can park in."

Between 4:20 and 4:30 p.m., the Petitioner was headed towards the lot with her colleague at an exit with five doors. She exited the door to her far left as she walked out, and as she walked in the outdoor area outside of the doors, she felt the toe of her shoe catch a groove between two sidewalk pavers and fell. The pavers are large approximately 2' x 2'.

She testified that when she caught her right toe she fell forward, landed on her left side on the pavers, hit her head and bent her glasses, and her right knee ended up over part of her body. She was wearing open toe Birkenstock sandals. She was dizzy, disoriented and nauseous when she fell, and needed help getting up. She testified that she needed help to get up, and that the colleague she was with then brought her to Anderson Hospital.

The Respondent's injury report documentation (dated 4/1/16) all indicates a consistent reported history of tripping between uneven grooves between sidewalk slabs. There was no loss of consciousness. A witness statement from Suranjan Weeraratne indicates that he and the Petitioner had made a presentation and were exiting Peck Hall towards the parking lot A. He was slightly ahead of Petitioner, but heard her fall, noting she had tripped on the concrete, and that he brought her to the hospital. (Rx1 through Rx3).

Petitioner testified that she had a head contusion and abrasion, and significant soreness in the right knee, neck and back. The Anderson Hospital report noted a history of the Petitioner tripping over uneven sidewalk and striking her forehead on the concrete. She reported a headache and dizziness but no loss of consciousness. She also noted left hand and neck pain, along with the development of anterior right knee pain. She had a left forehead hematoma. CT scans of the brain and cervical spine showed nothing acute, with some mild cervical spondylosis. Right knee x-rays, compared to June 2011 x-rays and August 2011 MRI, reflected no effusion or acute fractures, and mild to severe tricompartmental osteoarthritis with some loose fragments and a Baker's cyst. She was diagnosed with a minor head injury, cervical strain and right knee contusion, prescribed Ibuprofen, and was advised to see her primary provider, Dr. Reynolds, in 5 to 7 days. (Px1).

Petitioner saw Dr. Reynolds on 3/31/16, reporting she had been on a stone path at work, there were gaps between the large flat stones and she caught her foot, striking her head and injuring her right knee. She reported on and off mild headache and knee pain with standing and walking. The Petitioner testified that Dr. Reynolds recommended she follow up with an orthopedic surgeon for her right knee, and the report shows she was referred to Dr. Bicalho and for possible MRI. At a 5/26/16 follow up for multiple concerns, the Petitioner reported ongoing lateral right knee pain that radiated to the thigh and calf. Noting that only an MRI had been authorized, this was obtained on 5/27/16. The radiology report indicated: 1) moderate knee joint effusion with several intrascapular bodies, 2) a moderate Baker's cyst, 3) moderate chondromalacia (Grade 2 to 3 in all

compartments), 4) possible medial meniscus tearing or fraying, and 5) no ligament tears. On 6/13/16, Dr. Reynolds again recommended an orthopedic consultation. (Px1).

The Petitioner testified that she has been unable to see a surgeon because she could not be seen without workers' compensation authorization from the carrier. She testified that her head, neck and back "have been fine", but that her right knee hasn't improved and she still wants to seek treatment for this.

The Petitioner testified that she took the photographs in Px5, and that they accurately depict the noted groove between the pavers where she fell. The whitish caulking-type material seen in the photos exists between some of the pavers, but not all of them, and there is no symmetry as to which have it and which don't. The part where she caught her toe did not have this caulk-type material in the groove. She testified that Rx5(C) shows the white caulk between the pavers. The Petitioner testified that there was no uniformity regarding the caulk in the grooves, and that the photo in Px5 where her finger is in the groove was next to where her toe got caught, and that it was a part of the groove that actually had caulking in it.

The Petitioner also reviewed the photographs submitted into evidence by the Respondent (Rx5), and agreed they depict the area by Peck Hall where she fell. She also testified that the door she exited on 3/21/16 was depicted in Rx5(B) to the right of the handicapped entry button on the post. However, she said the location where she actually fell was not depicted in this photo, and would have been depicted if the photo were taken further to the right. The Petitioner was not sure what doors Rx5(D) showed, possibly a different entrance / exit, but they were not the entry/exit where she fell.

The Petitioner's job requires her to go to different buildings on campus, and she would have to take materials with her between buildings, including syllabi, curriculum, IPad, teaching materials and student materials. She was carrying those items when she fell.

The Petitioner testified that she missed three days of work immediately after the injury, and had signed a revocable waiver of TTD (Rx4).

The Petitioner testified to a prior work-related right knee surgery in 2007, and that she had recovered from that normally with no further problems until this incident. On cross examination, she testified that this 2007 surgery involved the removal of a piece of cartilage, and there was a tear of some sort outside of the knee. She agreed she had an aneurysm down in the right calf in 2011 after breaking her right ankle, but was not aware of such aneurysm being behind her right knee, though she had no reason to disagree if the medical records indicated this – this was indicated in the 3/21/16 notes from Anderson Hospital, along with a possible deep vein thrombosis in the right leg at that time. She also agreed that she has undergone two left knee surgeries.

Also on cross exam, the Petitioner testified that when was exiting the building and fell, she was leaving work for the day and was going to go home. She said that when she fell she had been carrying her curriculum, course syllabi, student handouts and her university assigned IPad in a messenger bag over her shoulder. She agreed that she didn't note that she was carrying anything when she completed the Respondent's Employee's Notice of Injury form. (Rx1).

The Petitioner agreed she only missed the three days of work, which the ER authorized (Px1), and otherwise has been working full duty without restrictions. She has not undergone physical therapy for this injury, but testified she does take pain and inflammation medications prescribed by Dr. Reynolds. She currently teaches online and so hadn't attempted to return to the classroom duty prior to the hearing date.

The Respondent's assistant grounds superintendent, Kert MacLaughlin, was called to testify by the Respondent. He indicated that his job involves taking care of anything related to the grounds outside of the buildings, including maintenance of sidewalks as far as removal of debris and obstructions.

Mr. MacLaughlin testified that if he gets notice of a sidewalk defect, his department would put a caution cone or barricade up, and notify Respondent, who would determine which party was responsible for repairs. Part of his job would also be to report such defects. He testified that he is familiar with the walkways around Peck Hall. He identified Rx5A and 5B as the west entrance to Peck Hall, and agreed his department maintains the area.

Mr. MacLaughlin testified that he is not aware of any defects in the walkway, and if he had been he would have reported it. He indicated that the caulk between the "pavers" is cosmetic, as the walkway is actually one large piece of concrete with exposed aggregate surface, and there are grooves cut into it rather than individual pavers. In reviewing the photos in Px5, he testified that he would not consider what was depicted to be defects.

On cross examination, he testified that he knows nothing about the Petitioner's fall other than what he heard during her hearing testimony. He knew the area where she fell, and that the entire area is covered by the pavers, but not the exact location where she fell. He and his crew regularly examine the area, noting they have to blow out and remove debris. He agreed that in some areas the caulk is gone due to weathering. He testified that it would be unusual for there to be pieces of broken aggregate or aggregate debris in the grooves, but that it is possible. If a break is found in the concrete and it separates, those sections would be cut out and repaired. With regard to the grooves depicted in Px5, he testified he would consider them normal and consistent with the rest of the groove gaps throughout.

The Petitioner has submitted medical expenses totaling $6,325.38 she alleges to be related to this case as Petitioner's Exhibit 3. The parties have stipulated that if the Arbitrator awards causally related reasonable and necessary medical expenses in this case, the Respondent shall pay same directly to the applicable medical providers pursuant to the Medical Fee Schedule in Section 8.2 of the Act or by PPO agreement, whichever as less, and that the Respondent is entitled to credit for any payment of the awarded medical that was made prior to hearing.

CONCLUSIONS OF LAW

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF THE PETITIONER'S EMPLOYMENT BY THE RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

The Arbitrator initially notes that the claimant has the burden of establishing, by a preponderance of the evidence, that her injury arose out of and in the course of her employment with the Respondent on 3/21/16.

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, 5 Ill. Dec. 854 (1977). Injuries sustained on an employer's premises, or at a place where the claimant might reasonably have been while performing her duties, and while a claimant is at work, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment. *Caterpillar Tractor Co. v. Industrial Comm'n*, 129 Ill. 2d at 57. The evidence indicates that the Petitioner had just exited her work building that day, Peck Hall, and fell just outside the door while she was walking

to her car, and while remaining on the Respondent's premises. Based on this evidence, the Arbitrator finds that the Petitioner's incident occurred in the course of her employment.

With regard to the second prong of the accident test, the Petitioner must show that the injury arose out of her employment with the Respondent. Both parties have cited the case of *Litchfield Healthcare Center v. Industrial Commission*, 812 N.E.2d 401, 349 Ill.App.3d 486, 285 Ill.Dec. 581 (2004), in support of their respective arguments in this case.

In *Litchfield*, after punching in at a time clock inside the employer's building, the claimant, a certified nursing assistant, realized that she had forgotten her "gait belt" in her car, exited the building and returned to her car to get it. After retrieving the gait belt, she began walking back to the building and tripped on an area of the sidewalk where the concrete slabs were not level with each other. She identified an exhibit, which showed one concrete slab higher than the adjoining slab, and testified that the height difference was approximately 1 1/4 inches. The Court determined that tripping on a sidewalk is a neutral risk of injury, and thus the question was whether the claimant had been exposed to a risk of injury to a greater extent than that to which the general public was exposed. The Court stated that "this case does not merely involve the risks inherent in walking on a sidewalk which confront all members of the general public." In support of this, they cited the claimant's testimony and photographs showing varying heights in the adjoining concrete slabs, the Court found that there was a defect or hazard in the sidewalk and, therefore, there was a causal connection between the condition of the premises and the injury: "Special hazards or risks encountered as a result of using a usual access route satisfy the 'arising out of' requirement of the Act." (citing *Bommarito v. Industrial Comm'n*, 82 Ill.2d 191, 412 N.E.548, 45 Ill.Dec. 197 (1980) and *Mores-Harvey v. Industrial Comm'n*, 345 Ill.App.3d 1034, 804 N.E.2d 1086, 281 Ill.Dec. 791 (2004)). *Id.*

Based on this case law, the Arbitrator reasons that the issue here becomes whether the neutral risk of traversing the walking area outside of Peck Hall involved a risk to the Petitioner which was greater than that encountered by the general public. The question is whether the paver-like gap created in the concrete where she fell constitutes a "special hazard or risk." The Arbitrator does not believe that the Petitioner has shown this through the evidence in the case.

The Arbitrator notes that the Petitioner testified that she tripped on a gap in the walkway surfaces. Mr. MacLaughlin testified that the walkway is actually a solid piece of concrete, as opposed to pavers, and has gaps carved into it to address expansion and contraction of the surface.

While the Petitioner testified that she has to traverse between multiple buildings on campus in the course of her duties, she did not testify with regard to the frequency with which she traveled to and from Peck Hall. The witness statement of Mr. Weeraratne indicates that he and the Petitioner had made a presentation there. It is unclear from the evidence whether this means that the visit to Peck Hall was unusual for the Petitioner or if she regularly visited this building. She did not testify as to how often she traversed the walkway in this area.

The Petitioner also has not provided any evidence that the messenger bag she was carrying on her shoulder contributed to her fall in any way, whether due to its weight or any impact on her vision.

There are no real measurements that were submitted into evidence with regard to the size of the gap where the Petitioner testified she fell. There are photographs in evidence. There is a photograph with the Petitioner putting her fingertip into one of the grooves. However, this does not really indicate exactly how

large this gap was. The photos in evidence which depict the entire area which appears to have pavers does not seem to the Arbitrator to show any significant gaps. Instead, it appears to show a fairly consistent

It appears to the Arbitrator that the Petitioner testified that the area which caused her to fall did, in fact, have caulk within it. Additionally, Mr. MacLaughlin testified that the caulk was placed for aesthetic purposes as opposed to as gap filler placed for safety. Given that this is a public university setting, the Arbitrator has to assume that this walkway is traversed very often by students and faculty alike, and no evidence was presented that anyone had ever had an issue with walking over the gaps in the concrete.

Overall, the Arbitrator finds that the gap the Petitioner tripped on is a very common thing encountered generally on concrete outdoor walking surfaces, and that there was no special defect or hazard proven in this case. Unlike the situation in *Litchfield*, there was no indication of an uneven walkway here, but rather a pretty typical gap between two pieces of concrete that her sandal happened to get caught in. The Arbitrator finds that the Petitioner has failed to prove an increased risk over and above that encountered by the general public.

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

Based on the Arbitrator's findings that the Petitioner failed to prove that she sustained accidental injury arising out of her employment with the Respondent on 3/21/16, this issue is moot.

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:

Based on the Arbitrator's findings that the Petitioner failed to prove that she sustained accidental injury arising out of her employment with the Respondent on 3/21/16, this issue is moot

WITH RESPECT TO ISSUE (K), IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE, THE ARBITRATOR FINDS AS FOLLOWS:

Based on the Arbitrator's findings that the Petitioner failed to prove that she sustained accidental injury arising out of her employment with the Respondent on 3/21/16, this issue is moot

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

Iris Anderson,

Petitioner,

vs.

NO. 10WC 36309

Peabody Coal Company,

17IWCC0511

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 occupational disease, permanent disability, and legal/evidentiary errors, 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 13, 2016 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.

17IWCC0511

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

DATED: AUG 18 2017

Stephen J. Mathis

SJM/sj
o-8/3/2017
44

David L. Gore

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
FATAL

ANDERSON, IRIS (PAUL)
Employee/Petitioner

Case# **10WC036309**

PEABODY COAL COMPANY
Employer/Respondent

17IWCC0511

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

0755 CULLEY & WISSORE
KIRK CAPONI
300 SMALL ST SUITE 3
HARRISBURG, IL 62946

2742 KEVIN M HAZLETT LLC
1167 FORTUNE BLVD
SHILOH, IL 62269

17IWCC0511

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
FATAL

IRIS (PAUL) ANDERSON
Employee/Petitioner

v.

PEABODY COAL COMPANY
Employer/Respondent

Case # 10 WC 36309

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 **Michael Nowak**, Arbitrator of the Commission, in the city of **Collinsville**, on **11/20/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. [ ] Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. [ ] Was there an employee-employer relationship?

C. [x] Did an accident occur that arose out of and in the course of Decedent'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 Decedent's current condition of ill-being causally related to the injury?

G. [ ] What were Decedent's earnings?

H. [ ] What was Decedent's age at the time of the accident?

I. [ ] What was Decedent's marital status at the time of the accident?

J. [ ] Who was dependent on Decedent at the time of death?

K. [ ] Were the medical services that were provided to Decedent reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

L. [x] What compensation for permanent disability, if any, is due?

M. [ ] Should penalties or fees be imposed upon Respondent?

N. [ ] Is Respondent due any credit?

O. [ ] Other _____

FINDINGS

On the date of accident, **10/28/2007**, Respondent ***was*** operating under and subject to the provisions of the Act.

On this date, an employee-employer relationship ***did not*** exist between Decedent and Respondent.

On this date, Decedent ***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.

Decedent's death ***is not*** causally related to the accident.

In the year preceding the injury, Decedent earned **$53,734.72**; the average weekly wage was **$1,033.36**.

On the date of accident, Decedent was **68** years of age, ***married*** with **0** dependent children.

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

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

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

The Arbitrator finds that Decedent died on **10/28/07**, leaving **1** survivor(s), as provided in Section 7(a) of the Act.

ORDER

Because Petitioner failed to establish that Petitioner's decedent had an occupational disease which arose out of and in the course of his employment, failed to establish that the condition of ill-being which resulted in his death is causally related to his employment with Respondent, and further failed to establish a timely disablement as defined in Section 1(e) of the Occupational Diseases Act, 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

10/4/16
Date

OCT 13 2016

FINDINGS OF FACT

Petitioner's decedent, Paul Anderson, worked as a coal miner from approximately 1967 to 1999. He retired in October 1999 when the Marissa Mine, near Marissa, Illinois, closed. Mr. Anderson was diagnosed with non-small cell lung cancer in July of 2006 and died on October 28, 2007. The medical certificate of death lists metastatic lung cancer as the only cause of death.

Petitioner filed an application for adjustment of claim on September 21, 2010, almost three years after the date of death. At issue is whether Mr. Anderson had a pulmonary condition of ill-being (other than the lung cancer), and, if so, whether this pulmonary condition was caused by his employment as a coal miner while working for Respondent.

Beginning in 1994 Mr. Anderson began seeing Dr. M. B. Prabhu, a pulmonologist, as his family doctor. On February 10, 1994 Dr. Prabhu first examined Petitioner as a new patient to his practice. Mr. Anderson was seen for complaints of persistent cough which had been going on since before Christmas. He admitted to smoking ½ to ¾ of a pack of cigarettes daily. Dr. Prabhu noted "This patient clearly has several problems. He has probably got infective bronchitis, maybe with an atypical organism with a background history of chronic bronchitis secondary to cigarette smoking." (PX 5, pp. 65-66) In the past medical history section Dr. Prabhu indicated "he has been told that he has arthritis and bronchitis." *Id.*, at 66. He prescribed an antibiotic and gave Mr. Anderson an Atrovent inhaler. *Id.*, at 65. The diagnoses on that date were bronchitis, hypertension, and enlarged prostate.

Dr. Prabhu treated Mr. Anderson for various complaints over the next five years. None of those complaints involved any respiratory or pulmonary complaints or symptoms, either acute or chronic. No medications for breathing problems were prescribed during this time.

On December 22, 1999, two months after retirement, Mr. Anderson presented himself to Dr. Prabhu for a "black lung physical". The office note indicates Mr. Anderson had faint expiratory wheezes on auscultation of his lungs and pulmonary function tests showed an "asthma component." There is no diagnosis of chronic bronchitis, COPD, or coal workers' pneumoconiosis. A flovent 44 inhaler was given. *Id.*, at 57. Curiously, on March 31, 2000 Dr. Prabhu completed a U.S. Department of Labor Medical History and Examination for Coal Mine Workers' Pneumoconiosis in which he diagnosed pneumoconiosis, emphysema, and hypertension caused by coal dust exposure and cigarette smoking." *Id.*, at 134. Dr. Prabhu indicated he relied upon a chest x-ray of March 27, 2000, a pulmonary function study of December 16, 1999, and an arterial blood gas study of December 16, 1999 in formulating his diagnosis. *Id.*, at 133. The Arbitrator notes that these diagnoses and test results appear nowhere else in Dr. Prabhu's records except the Department of Labor documents.

At arbitration, Petitioner testified that she did not know if Mr. Anderson filed a state black lung claim while he was alive. She did confirm that his federal black lung claim was denied.

Dr. Prabhu saw Mr. Anderson twice in June 2000 for medical problems unrelated to his lungs, although on June 7, 2000 there is a notation indicating he still had faint expiratory wheezes on auscultation of his lungs. *Id.*, at 55. On June 21, his lungs were clear to auscultation. *Id.*, at 54. There are no medical records showing any treatment between June 2000 and December 2003.

On December 3 and 8, 2003 Mr. Anderson was treated for ear problems. He was noted to have no cough or exertional dyspnea. His lungs were again clear to auscultation. *Id.*, at 50-52.

He next returned to the doctor in October 2004 for hypertension complaints. He denied cough or sputum production and his lungs were clear. He indicated he had ceased cigarette smoking 5 years ago. *Id.*, at 48. He was treated for hypertension throughout 2005. When he returned on January 5, 2005 he was noted to be smoking again and indicated he was under a lot of stress because he was building a new house. His lungs were clear with no wheezes or crackles. *Id.*, at 46. When Mr. Anderson returned on March 16, 2005 he denied shortness of breath, cough or sputum production. His lungs were again noted to be clear with no wheezes or crackles and no flank bruit. Curiously this note indicates he had been a non-smoker for 6 years. *Id.*, at 44. On July 22, 2005 Mr. Anderson reported he had "been working hard at pouring concrete and putting the finishing touches on a house." He denied shortness of breath, cough or sputum production. His lungs were again noted to be clear with no wheezes or crackles and no flank bruit. *Id.*, at 42.

He was next seen on February 6, 2006 for complaints signs of an upper respiratory infection for one week. He reported a cough which was productive of yellowish phlegm and a runny nose. He was diagnosed with sinusitis. *Id.*, at 38. On February 8, 2006 Mr. Anderson phoned Dr. Prabhu requesting an urgent appointment noting increasing shortness of breath and complaining that he was "tight and wheezy." He was admitted to the hospital. *Id.*, at 37.

On February 17, 2006 Mr. Anderson returned to Dr. Prabhu's office. It was noted that he was recently hospitalized with an episode of pneumonia. It was further noted that "[h]e has a remote history of cigarette smoking, but he (sic) smoking three years ago." Examination revealed "[b]reath sounds are diminished but lungs sound clear. No wheezes or crackles are heard." The diagnosis was "[r]ight lung nodule with pneumonia." A bronchoscopic examination of the airways was planned for the following week. *Id.*, at 36. He was next seen on March 6, 2006. That note indicates:

> He was recently in the hospital with a right lung pneumonia. We found multiple nodules in his right lung. Bronchoscopy was clear. However bronchial washings has (sic) shown the presence of Streptococcus pneumoniae.
>
> The patient says he is feeling better. He has very little cough or sputum at this time. He quit smoking about three years ago. He denies any chest pain or palpations. No limitation of activity. No GI symptoms. *Id.*, at 34.

Dr. Prabhu's relevant assessments at that time were right lung nodule, right lung infection with Streptococcus pneumoniae at bronchoscopy, and COPD from previous cigarette smoking. *Id.*

Mr. Anderson saw Dr. Prabhu next on June 8, 2006 for follow up. The doctor noted there was no evidence of malignancy in previous testing. It was further noted that he had shoulder pain and had been working on building a house. The lungs were clear with no wheezes or crackles. The assessments included" right lung nodule, stable," and "COPD from previous cigarette smoking, stable." A chest CT with contrast was recommended to follow up on the right lung nodule. *Id.*, at 32-3. Following the CT scan Mr. Anderson returned to Dr. Prabhu on June 21, 2006. The CT scan had revealed that the right lung nodule was increasing in size and showed an endobronchial lesion which was not present at his first bronchoscopy. Dr. Prabhu recommended a

pulmonary function test to determine if he was a candidate for resection, and if so move forward with resection of the nodule and have it evaluated to determine if it was a malignancy. *Id.*, at 31. Pulmonary function testing was performed that same date by Dr. Prabhu at St. Vincent Memorial Hospital. The PFT showed evidence of reduced flow rates with airway obstruction which did not improve following the introduction of a bronchodilator. The doctor concluded "[t]he patient's FEV1 is 1.87 liters and this would indicate that the patient would tolerate right middle and if necessary right lower lobectomy but would be a marginal candidate for right pneumonectomy." *Id.*, at 81

In July, 2006 Mr. Anderson was referred to Dr. Bretscher at Springfield clinic for treatment of his non-small cell lung cancer. Mr. Anderson ultimately succumbed to the disease on October 28, 2007. The medical certificate of death lists metastatic lung cancer as the only cause of death.

The application for adjustment of claim was filed on September 21, 2010, almost three years after the date of death.

Respondent obtained a medical records review by Dr. Selby who authored a report dated January 11, 2012. Dr. Selby prepared a 32 page report summarizing the voluminous medical records, and providing his opinions as well as the basis for his opinions.

Three years after filing the application for adjustment of claim, Petitioner's counsel sent a letter to Dr. Prabhu dated October 7, 2013 summarizing counsel's review of the medical records and posing 20 questions to the doctor regarding whether Mr. Anderson had COPD and chronic bronchitis.

In March 2014 Dr. Houser performed a medical record review at the request of Petitioner's counsel and issued a report dated March 24, 2014.

Dr. Prabhu's evidence deposition was taken on December 17, 2013. Dr. Prabhu testified that he treated decedent Paul Anderson from around 1994 up until the time of his death on October 28, 2007. (PX 2, p 9) Dr. Prabhu testified that Decedent had COPD and his opinion was that it was caused in part, aggravated or made worse by his exposures as a coalminer. *Id.*, at 15. Dr. Prabhu also testified that he believed Decedent had chronic bronchitis, which was caused in part or aggravated and made worse, in part by his exposure as a coalminer. *Id.*, at 15-16. Dr. Prabhu also testified that he believed Decedent had emphysema, which was also related to his coalmining exposure. *Id.*, at 16. The doctor felt that Decedent also had asthma and that the exposure to roof bolting glue fumes and diesel fumes, in his work as a coalminer, as well as the coal dust exposure would have been a causative factor or an aggravating factor, which could have made his asthma worse. *Id.*, at 16-17. Dr. Prabhu testified that decedent's terminal event was hastened and contributed to by his pneumonia, chronic airway obstruction, and chronic bronchitis with exacerbation. *Id.*, at 18. He further opined that Decedent's chronic airway obstruction and chronic bronchitis with exacerbation along with his asthma, made him more susceptible to pneumonia by providing the best breeding ground for the virus or the bacteria to cause the pneumonia. *Id.* Recovery from pneumonia was also made more difficult by his underlying chronic diseases including his asthma. *Id.* Dr. Prabhu testified that the severity of Mr. Anderson's pulmonary disease prevented surgery for his lung cancer and confined his treatment to chemotherapy and radiation therapy. The doctor felt the best form of treatment for lung cancer would be surgery to remove the cancer. *Id.*, at 19. Dr.

Prabhu also testified that if decedent was exposed to a significant amount of diesel fumes at his job the exposure could have been a causative factor for lung cancer. *Id.*, at 19-20.

On cross-examination Dr. Prabhu conceded that the letter submitted by Petitioner's counsel did not provide specific dates for complaints or symptoms. For example, counsel indicated the records showed five entries of cough, but did not specify when those entries were made. However, everything in the letter submitted by Petitioner's counsel related to medical care and treatment after Mr. Anderson last worked as a coal miner in October 1999. *Id.*, at 29. He confirmed that the conditions he treated were acute bronchitis, not chronic bronchitis. *Id.*, at 30-31. He admitted that chronic bronchitis is a historical diagnosis. *Id.*, at 31. He confirmed he did not treat Mr. Anderson for any pulmonary complaints between the acute bronchitis event in February 1994 and his retirement in October 1999. *Id.*, at 32-33. He agreed that if Mr. Anderson had chronic bronchitis between his retirement in October 1999 and his death in 2007 he would have documented that in his office records. There is no such documentation in his records. In fact, if Mr. Anderson had symptoms of chronic bronchitis he would have been treated with medication and no medication was prescribed. He confirmed that Petitioner stopped smoking in 1998 or 1999 but started smoking again in the mid 2000's. *Id.*, at 34. Testing in February 2006 revealed findings of pulmonary nodules and the diagnosis of cancer was made. Mr. Anderson's treatment for pneumonia in 2006 was caused by streptococcus pneumoniae. *Id.*, at 36. Dr. Prabhu admitted that he did not diagnose emphysema or asthma before June 2006. *Id.*, at 37.

Dr. Houser testified by deposition as well. Dr. Houser performed his records review concerning Mr. Paul Anderson on March 24th, 2014. (PX 1, p 8) Dr. Houser reviewed the following information:

1. Dr. Prabhu medical records.
2. Dr. Prabhu letter dated 10/7/13
3. Dr. Prabhu's deposition
4. St. Vincent Hospital records
5. Springfield Clinic records
6. Dr. Mary Bretscher's records
7. Memorial Hospital CT report
8. A copy of the death certificate *Id.*, at 9.

Dr. Houser's summary of the medical records and his opinions are contained in his three page report. Dr. Houser found that pulmonary function studies performed in 1999 and 2006 both show moderately severe chronic obstructive pulmonary disease. He felt the CT scan also documents that Mr. Anderson had evidence of emphysema. Dr. Houser opined that:

> Mr. Anderson's emphysema was due to the inhalation of coal and rock dust arising from his former coal mine employment and former cigarette smoking. Both emphysema and exposure to the diesel exhaust are risk factors for the development of lung cancer. The severity of Mr. Anderson's COPD/emphysema precluded surgical treatment for his lung cancer. Surgical treatment, by far, is the preferred measure for dealing with lung cancer and is the only treatment with any reasonable expectation of curing the effected individual. Although Mr. Anderson's immediate cause of death was metastatic lung cancer, for the reasons

> outlined above, his emphysema was a significant factor in causing the disease, limiting effecting therapy, and ultimately was a significant factor causing his death." *Id.*, at 15.

On cross examination Dr. Houser estimated he spent 30-45 minutes reviewing medical records and the deposition of Dr. Prabhu. *Id.*, at 47. It took about one hour to prepare his written report. He spent 10-15 minutes performing his medical literature research. *Id.*, at 48. In his report he indicated that Mr. Anderson's conditions precluded surgical treatment for his lung cancer. However, he conceded on cross examination that the treating physician, Dr. Prabhu, had indicated Mr. Anderson could tolerate a right middle and, if necessary, a right lower lobectomy but would be a marginal candidate for a right pneumonectomy. Dr. Houser confirmed that Dr. Prabhu did not state that Mr. Anderson was not a surgical candidate but that he probably could tolerate one or two lobes and that he would be a marginal candidate for a pneumonectomy. *Id.*, at 53-54. He reiterated that Mr. Anderson was capable of having perhaps 2/3 of his right lobe removed. *Id.*, at 54. In his report he referenced a note of Dr. Mary Bretscher dated October 1, 2006. Dr. Houser indicated in his report that Dr. Bretscher stated "'he was found not to be a surgical candidate due to the COPD.'" *Id.* On further questioning he could not identify the source of this quotation in his report. *Id.*, at 55. Dr. Houser did not review any radiological or radio graphical films. He agreed that a diagnosis of chronic bronchitis is a historical diagnosis based only on the history provided by the patient. *Id.*, at 57. He agreed that chronic bronchitis can improve or resolve. *Id.*, at 59. Dr. Houser could not recall or locate any medical records indicating Mr. Anderson received medications for his breathing problems. *Id.*, at 61.

Dr. Houser's opinions regarding emphysema being a risk factor for the type of cancer Mr. Anderson developed was primarily based on a minimal study performed at the Mayo Clinic 28 years earlier. Dr. Houser was not aware of a more involved or elaborate study. *Id.*, at 65. He confirmed that Petitioner's counsel did not send him that same 20 question letter which had been provided to Dr. Prabhu. *Id.* Dr. Houser conceded he did not have any specific information or direct knowledge of Mr. Anderson's exposure to diesel fumes or diesel exhaust while working for Respondent as a coal miner. *Id.*, at 69.

Dr. Selby testified by deposition as well. Dr. Selby spent more than 8 hours reviewing the records and preparing his report. (RX 1, p. 37) Dr. Selby opined that Mr. Anderson did not have coal workers' pneumoconiosis. Dr. Selby opined that Mr. Anderson had the pulmonary and respiratory capacity to perform any and all prior required coal mine jobs or duties including his last job at the mine. Mr. Anderson had emphysema due to 30 + years of cigarette smoking. Mr. Anderson died as a direct result of cigarette smoke causing non-small cell lung cancer. Coal mine dust inhalation did not cause or contribute to his lung cancer. He further opined that coal mine dust did not shorten Mr. Anderson's life or contribute to his death.

CONCLUSIONS

The evidence taken as a whole does not support Petitioner's claim. The records of Dr. Prabhu, Mr. Anderson's treating physician, do not document a diagnosis of chronic bronchitis or COPD. A single reference to the term chronic bronchitis was noted by Dr. Prabhu based on a statement by Mr. Anderson that he had been told he had the condition. There is no medical evidence to support this condition as a diagnosis. Dr. Prabhu's records cover treatment for more than 5 years before Mr. Anderson retired and for almost eight years thereafter.

Dr. Prabhu's opinions were a response to questions and information provided in a letter prepared by Petitioner's counsel six years after Mr. Anderson's death and three years after the application was filed. Cross examination of Dr. Prabhu revealed numerous inconsistencies and inaccuracies in the history provided and his conclusions and opinions. His after the fact opinions are not supported by his own medical records.

Dr. Prabhu's deposition was taken on December 17, 2013. After Dr. Prabu's deposition Petitioner's counsel sent the medical records to Dr. Houser in March 2014. Dr. Houser's opinions are questionable in that he performed a minimal cursory review of hundreds of pages of medical records then issued a report containing inconsistencies and inaccuracies. He stated that surgical treatment by far is the preferred measure for dealing with lung cancer and that medical evidence indicated Mr. Anderson was not a surgical candidate. The overwhelming medical evidence contradicts this opinion. Dr. Mary Bretscher indicated that Mr. Anderson could have substantial surgery but was a marginal candidate for a right lung pneumonectomy. Dr. Prabhu testified that he was aware of her opinion and agreed with it. Dr. Houser even conceded on cross-examination that the medical records indicated Mr. Anderson was a surgical candidate. He further indicated that exposure to diesel exhaust is a risk factor for the development of lung cancer, but he had no information regarding Mr. Anderson's exposure, if any, to diesel fumes or diesel exhaust while working for Respondent.

The medical records of Dr. Prabhu do not support a diagnosis of chronic bronchitis, COPD or coal workers pneumoconiosis during Mr. Andersons last five years of employment and in the eight years between his retirement and death, other than the U.S. Department of Labor Medical History and Examination for Coal Mine Workers' Pneumoconiosis prepared on March 31, 2000 in which he diagnosed pneumoconiosis, emphysema, and hypertension caused by coal dust exposure and cigarette smoking. The records confirm a few sporadic office visits and treatment for acute bronchitis or acute sinusitis.

The death certificate lists metastatic lung cancer as the immediate cause of death. No other underlying causes are listed.

Based on the totality of the evidence, the Arbitrator finds Dr. Selby's opinions to be more persuasive than those of Dr. Prabhu and Dr. Houser.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner has failed to prove by a preponderance of the evidence that Petitioner's decedent had an occupational disease arising out of and in the course of his employment. Compensation is therefore 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

Carol Glisson,
Petitioner,

vs.
Wal-Mart,
Respondent,

NO: 14 WC 26916

17IWCC0512

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, temporary total 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 October 28, 2016 is hereby affirmed and adopted.

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

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $1,200.00. 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 18 2017

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mas
o:8/1/17
43

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

GLISSON, CAROL
Employee/Petitioner

Case# **14WC026916**

17IWCC0512

WAL-MART
Employer/Respondent

On 10/28/2016, 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 0.47% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4463 GALANTI LAW OFFICES
LESLIE N COLLINS
PO BOX 99
E ALTON, IL 62024

0000 WIEDNER & McAULIFFE LTD
KRISTOPHER S DUNARD
8000 MARYLAND AVE SUITE 550
ST LOUIS, MO 63105

STATE OF ILLINOIS)
)SS.
COUNTY OF MADISON)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CAROL GLISSON
Employee/Petitioner

v.

WAL-MART
Employer/Respondent

Case # 14 WC 26916

Consolidated cases: _____

17IWCC0512

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 **Christina Hemenway**, Arbitrator of the Commission, in the city of **Collinsville**, on **May 26, 2016**. 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, **February 19, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned $**$22,278.36**; the average weekly wage was $**428.43**.

On the date of accident, Petitioner was **59** 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 $**693.67** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**693.67**.

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

ORDER

As explained in the Arbitration Decision, Petitioner sustained an accident which arose out of and in the course of her employment with Respondent on February 19, 2014. Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being is causally related to her accident at work on February 19, 2014. Petitioner reached maximum medical improvement for her chest wall strain on June 16, 2014. All benefits after that date are denied. Respondent is not liable for unpaid medical bills set forth in Petitioner's Exhibit 11 and is not liable for prospective medical care.

Respondent shall pay temporary total disability benefits of $285.62 per week for 6 2/7 weeks, for the periods of April 25, 2014, through May 9, 2014, (2 1/7 weeks), and from May 19, 2014, through June 16, 2014, (4 1/7 weeks), for a total of $1,795.33. Respondent shall receive credit for $693.67 previously paid.

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

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

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

Signature of Arbitrator

October 26, 2016
Date

ICArbDec19(b)

OCT 28 2016

17IWCC0512

STATE OF ILLINOIS)
) SS
COUNTY OF MADISON)

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

CAROL GLISSON
Employee/Petitioner

v. Case #: 14 WC 26916

WAL-MART
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

On her date of accident, February 19, 2014, Petitioner was 58 years old, married, with no dependent children. She was employed by Respondent as a sales clerk in electronics, and had been so employed for five years. Petitioner testified that her duties included putting stock away, retrieving TV's, taking purchases to customers' cars, and the like. On the date of accident, she was retrieving a 50-inch TV from the rack in the back room for a customer. There was a box on the floor, which she had to straddle and reach around. She grabbed the TV, which started to fall, causing her right arm to be hyperextended backwards. She testified she felt something pull in her chest. She reported the accident shortly thereafter. Petitioner did not know the weight of the TV, but testified it was a 50-inch TV and the box was approximately three feet tall, four and one-half feet long, and three inches wide. She testified that normally someone is there to assist with moving these boxes; however, there was no one there to help on that date.

Following the accident, Petitioner felt a burning pain in her chest and thought she pulled a muscle. She finished working that day, worked her full shift the next day, was off the following day, and returned the next day, which was Sunday. She testified that by 2:00 that day she was hurting so bad she went to her supervisor and told her she was having trouble breathing. She left work and went to the hospital, where she had x-rays and was told to follow up with her primary doctor, Dr. Jain, which she did the following day.

Petitioner testified she treated with Dr. Jain for a couple of months, who then referred her to Dr. Matz in June 2014. She did not see Dr. Matz, however, until November 2014 because she had foot surgery which was unrelated to her work accident. She testified she had previously treated with Dr. Matz for two cervical surgeries and a lumbar surgery. She also treated with him in 2012 after being rear-ended in a motor vehicle accident. She was injured in the accident and had pain in her neck, down both arms, and in her right ribs. She testified the symptoms at that

time were mostly in her back area and her arms, never in her chest, and resolved after about two months. Whereas, her current symptoms are shortness of breath and a burning sensation from raising her arms and pain from her chest into her back and side.

Petitioner saw Dr. Matz in November 2014, who ordered an MRI and physical therapy. She testified she underwent therapy at Community Memorial, but was unable to complete it because it caused severe headaches, so she quit going. She continued having symptoms of feeling pressure when her arms were hanging down or when she used her arms. She attended an independent medical examination by Dr. Bernardi in June 2015, and he recommended physical therapy and work hardening. Petitioner testified Dr. Jain would not order the therapy, as she had already tried it and it didn't work. Upon the recommendation of her attorney, Petitioner presented to Dr. Mark Eavenson on December 23, 2015. He ordered a thoracic MRI and recommended Petitioner see Dr. Matthew Gornet, which she did.

Petitioner testified Dr. Gornet is treating not only her thoracic spine but also her cervical spine, and he recommended injections into both areas. She had two injections to her thoracic spine, which provided no relief. She had one injection to her cervical spine, but further injections were cancelled because they were not authorized. She was scheduled to return to Dr. Gornet on the day of trial, and wished to follow his treatment recommendations. It was her understanding that Dr. Gornet did not recommend surgery her to her thoracic spine.

On cross-examination, Petitioner acknowledged that her complaints to the emergency room on February 23, 2014, were pain to the right chest and pain in the upper abdominal area. She also acknowledged that on the Associate's Statement she completed for Respondent on February 25, 2014, she reported pain in the right side of her chest and arm. She conceded there was no mention in her report of pain in the neck or back. Petitioner testified she had two prior cervical surgeries, in 2001 and 2011. Following the motor vehicle accident in March 2012 she presented to the emergency room with complaints of pressure in her chest. She treated with Dr. Matz for cervical, thoracic, and lumbar spine issues, and in May 2012 described her pain as going from the right subscapular area to around her chest. She underwent cervical MRI and thoracic x-rays, and ultimately had lumbar surgery in November 2012. Petitioner acknowledged that since that time she had been on pain medication, including up to the time of her work accident. She also actively treats for anxiety/stress/depression, high blood pressure, and arthritis.

Petitioner acknowledged that if the medical records indicated she first reported complaints of mid-thoracic or back pain on June 16, 2014, she would not dispute that. On that date, she reported to Dr. Jain that she had pain in her mid-back, over her shoulder, and through her chest. She did not recall Dr. Jain telling her that he was unable to state whether the work injury caused those complaints, due to the fact that she previously had similar pain. However, she did not dispute Dr. Jain's records. Petitioner testified she then saw Dr. Matz a couple of times, who recommended physical therapy, but advised her that he did not handle worker's compensation cases. She discussed the matter with her attorney, who then recommended she see Dr. Eavenson. He referred her to Dr. Gornet, who recommended injections. Petitioner testified the first thoracic injection improved her pain for only about three days, and the second injection gave her no relief at all. The cervical injection also did not improve her symptoms. She testified

she was following up with Dr. Gornet on the day of trial, but did not know what additional treatment he was recommending.

Petitioner testified there were a couple periods of time during which she returned to work for Respondent on a light duty basis. There were also periods of time during which she received short-term and then long-term disability benefits. She further testified that she was currently on Social Security Disability and had been for roughly a year. She acknowledged that she currently works at a hair salon one day a week. Prior to the accident she worked three days a week and some evenings, and prior to working for Respondent she had worked more. She acknowledged that she was still employed by Walmart.

On re-direct, Petitioner explained that the pain she reported to Dr. Jain March 2, 2014, was the same pain she had in June 2014, which Dr. Jain indicated was thoracic pain. She testified the pain started in her chest, between her breasts, and went around to the back at about the level of her bra strap. She described it as a knot or pressure, which made her feel short of breath, and which would radiate down into the right rib cage and around to the back on the right. She testified the pain has never gone away.

PRIOR MEDICAL RECORDS

Respondent submitted Petitioner's medical records for treatment dating back to 2000. The most pertinent of those records are briefly summarized in chronological order.

On November 27, 2000, Petitioner presented to Dr. Harry Cole of Neurology and Neurosurgery, upon referral by Dr. Jain. She complained of cervical and low back pain for at least two years, with no injury. Her symptoms were aggravated by her employment as a beautician. She had pain down both arms with occasional tingling and numbness. On December 11, 2000, she underwent an EMG/NCS, which was normal, and a lumbar MRI, which revealed bulges at L3-4, L4-5, and L5-S1. She also underwent a cervical MRI, which revealed C6-7 herniation, C4-5 protrusion, and C3-4, C5-6 bulges. Petitioner underwent cervical surgery on January 4, 2001, consisting of an anterior discectomy and fusion at C6-7. RX7.

On July 23, 2001, Petitioner returned to Dr. Cole with complaint of pain in the interscapular region for about six weeks, with occasional pain into her left arm. It was noted she was employed as a hairdresser, which tended to aggravate the symptoms. She had restricted range of motion but no spasms. On October 29, 2001, she returned to Dr. Cole with complaints of pain in her left arm and numbness and tingling in her (dominant) left hand. She underwent an EMG/NCS on November 12, 2001, which did not show median nerve entrapment. Dr. Cole recommended a repeat cervical MRI, but the record is unclear whether that took place. RX7.

The next record from Dr. Cole is January 19, 2011, when Petitioner was referred by Dr. Jain for cervical pain. She related she was doing well until one year prior when she fell, causing onset of cervical pain and pain in the interscapular region and down into her shoulders. The pain had worsened in the past eight months. She reported she had also had chest pain, which had prompted a thorough cardiac evaluation, including a coronary angiogram which was normal. Dr. Cole reviewed a recent cervical MRI, which showed a herniation at C3-4, slight bulges at C4-5

and C5-6, and a solid fusion at C6-7. Dr. Cole ordered traction for two weeks and noted Petitioner made need fusion at C3-4. RX7.

On February 7, 2011, Petitioner presented to Dr. Paul Matz, upon referral by Dr. Cole, who was in the same practice group. Treatment at that point was taken over by Dr. Matz. She reported pain in the back and right neck, secondary to a fall. She also had numbness and tingling, consistent with C3-4 disc displacement. On February 21, 2011, she underwent cervical surgery consisting of C3-4 anterior discectomy and fusion. On March 22, 2011, she reported an episode of stiffness on the right side of her neck and some tingling in her shoulder. On May 20, 2011, she reported that a box had hit her in the head, causing some pain in the head and left shoulder in the area of the rotator cuff. On August 17, 2011, Petitioner reported she had fallen in July, hitting the right side of her head. She complained of pain in her neck and interscapular area and hypesthesia in both arms and both legs in what Dr. Matz described as a "stocking glove distribution". Impression was concussion with post-concussive headaches that had improved. Dr. Matz recommended a cervical MRI and EMG/NCS. The record does not contain an MRI report. The EMG/NCS showed mild left ulnar compression neuropathy, mild sensory and motor neuropathy, and no evidence of radiculopathy, plexopathy or myopathy. RX7.

The next record is April 10, 2012, when Petitioner presented to Dr. Matz following a motor vehicle accident on March 28. She was rear-ended and her head went back and forth. She was not wearing a seatbelt and the airbags did not deploy. She complained of pain in her neck and shoulder blades, tingling in the neck, some radiation of pain down into the arms, pain between her shoulder blades, and pain around her ribcage. She reported she worked as a hairstylist, and that it was painful when she held her arms up for long periods of time. It was recommended she have physical therapy. On May 15, 2012, she returned with two issues. She complained of pain in the subscapular area, going around the right ribs and into the interscapular area. She also complained of stiffness and limited range of motion in her neck. She reported physical therapy did not give any relief. Assessment was neck sprain/strain, neck ache, and thoracic back pain. A cervical MRI that day revealed post-surgical changes at C3-4 and C6-7, mild spinal canal narrowing at C5-6, and mild left foraminal narrowing at C4-5 and C5-7. Chest x-ray was negative for active cardiopulmonary disease. Thoracic x-ray showed mild kyphoscoliosis and degenerative spondylosis. RX7.

On November 8, 2012, Petitioner presented to Dr. Matz and reported that on October 2 she was at work "doing some activities" and felt pain in her buttock and leg after a popping sound. It was noted a prior MRI showed degenerative disease. She complained of pain in the back down both legs and sharp pain into her right buttock, thigh, and leg. A lumbar MRI revealed right L4-5 disc displacement with superimposed free fragment and lateral recess. On November 14, 2012, Petitioner underwent lumbar surgery consisting of L4-5 laminectomies and foraminotomies, and right L4-5 discectomy. PX7.

On October 25, 2013, Petitioner reported to Dr. Matz that she had had pain in her back and both legs for about four months. A lumbar MRI was done on November 14, 2013, which showed L5-S1 spondylosis, post-op scarring, and right lateral foraminal disc protrusion; mild bulge at L3-4; minimal bulge at L2-3; and minimal bulge at L1-2. RX7. Dr. Matz discussed the MRI results with Petitioner by phone on November 19, 2013. At that time, she reported she had

some periscapular pain, as well as pain in her left arm and hip. Dr. Matz ordered a pelvic x-ray to look for hip arthritis and a cervical x-ray to look for degeneration. The record does not contain either of those x-ray results and it is not clear whether they were done. PX3.

POST-ACCIDENT RECORDS

Following the accident, Petitioner presented to the emergency room at Anderson Hospital on February 23, 2014. She reported she had to catch a heavy TV that jerked her arm and she thought she pulled a muscle in her chest. She had sharp pain to her right upper chest and right upper abdomen which increased with deep breaths. It was noted, "She takes Vicodin chronically for neck and back pain. This has not helped with her right side pain." Chest x-ray and CT angiography were negative for acute cardiopulmonary disease or pulmonary embolism. The discharge diagnosis was right chest pain, musculoskeletal, and Petitioner was instructed to follow up wither her primary care physician. PX1, PX5.

On February 25, 2014, Petitioner completed an Associate Incident Report for Respondent. She stated that she reached to get a 50 inch TV, it started to fall, she grabbed it and her right arm was bent back in the process. She further stated she sustained a pulled muscle in the right side of her chest and arm. She denied having been treated for a similar injury. RX6.

On February 28, 2014, Petitioner presented to her family physician, Dr. Rajneesh Jain at Staunton Clinic. She reported right chest pain, with the pain primarily in the right anterior chest and radiating into the right axilla. The pain was moderate to severe, worse with coughing, deep breathing, exertion, postural change, and twisting. Associated symptoms included anxiety and myalgias. She gave a consistent history of grabbing a large TV which was falling, which stretched her right arm. Assessment was right chest wall musculoskeletal pain, and Petitioner was instructed to avoid lifting for three to four weeks. PX2. The Arbitrator notes that page one of this record does not appear to be complete, in that the bottom half of the page is blank and the last sentence appears to be partially cut off. It appears that the bottom half of the page was obscured when copied. As such, the History and Physical (HPI) is not complete.

Petitioner returned to Dr. Jain on March 28, 2014, with continued complaints of chest wall musculoskeletal pain, in the right anterior chest and radiating to the right axilla. On examination it was noted she had paresthesia in the right chest wall area and tenderness over the right anterior and lateral chest wall. She was instructed to avoid lifting for three to four weeks. She followed up on April 25, 2014, with continued complaints but indicated she was somewhat improved. She reported that her job did not provide any opportunity to work which did not involve some form of lifting, that as soon as she started to lift her symptoms reappeared, and that they completely resolved as long as she did not lift. She continued to have tenderness over the right anterior and lateral chest wall. Dr. Jain instructed Petitioner to remain off work completely for three to four weeks. PX2.

On May 9, 2014, Petitioner followed up with Dr. Jain. The medical record from this date appears to be nearly identical to the record from April 25, with regard to complaints and examination. Petitioner was instructed to work at only a sitting job for six weeks. She returned to Staunton Clinic on May 19, 2014, and was seen by Nurse Practitioner Tonya Darr. It was

noted, "She presents with chest burning, wants off work." She reported she had been on light duty, sitting down on a stool with her arms hanging. She stated she was working in a fitting room, but that the job consisted of getting up and down off the stool, hanging clothes, putting up returns, and doing overhead activities. She reported it was "not a sitting job". She complained of pain and burning in her chest after she worked and she was wanted to get it relieved. Petitioner was instructed to remain off work due to muscle strain and chest pain and to follow up in three weeks. It was noted she would be on vacation until June 15, and that the appointment needed to be after she returned. PX2.

On June 16, 2014, Petitioner returned to Dr. Jain. He noted, "Now she is complaining of mid thoracic pain which radiates to right chest wall in a radicular pattern. She has history of mid thoracic pain. I have explained to her that it is difficult for me to state definitely whether her work related injury is causative or contributory to current pain or if this is recurrence of her previous pain." Examination revealed tenderness over the mid thoracic spine and lateral chest wall. Dr. Jain recommended Petitioner be reassessed by her neurosurgeon Dr. Matz, "to sort through this complicated clinical presentation". He noted she was due to be off work for unrelated surgeries for about six weeks, and then would see Dr. Matz. Dr. Jain also noted, "She had question about being disabled from work and I suggested she contact an attorney who deals with this matter for accurate advice in this matter." PX2.

The next record is November 21, 2014, when Petitioner presented to Dr. Paul Matz. She reported having a work injury when lifting a 55 inch TV which fell on her right shoulder. The Arbitrator notes this is a different history than previously given by Petitioner. She reported that after the incident she had "pain located in her right shoulder associated with fatigue in her right arm". She also reported having some incidental fatigue in the right leg. She stated these symptoms had been present on a daily basis since her injury. It was noted she had a history of cervical disc disease at C3-4 and C6-7 with surgeries in 2011 and 2001, as well as lumbar disc disease with surgery in 2012. She reported she was back at work for a week and a half but could not maintain the work due to her discomfort. Her current symptoms were primarily neck pain, fatigue in the right arm and leg, and low back pain. She rated her pain at 7/10. She reported she was able to do her activities of daily living, but was not working. Review of systems was positive for anxiety and depression. Neurologic exam revealed breakaway weakness in the right biceps and right hip flexor, as well as diminished sensation in the right thumb and index finger, and in a stocking distribution in the right leg. Dr. Matz noted he reviewed a cervical CT scan done at Barnes Hospital on August 26, 2014. The Arbitrator notes that this CT scan was not submitted into evidence and it is unclear who ordered the scan or why. Assessment was cervical disc herniation, neck sprain and strain, and lumbar disc displacement. Based on the weakness in her right arm and leg, Dr. Matz ordered lumbar and cervical MRI's. Petitioner was instructed to "stay as active as her disease process will allow and minimize bedrest". The Arbitrator notes there is no mention regarding Petitioner's ability or inability to work. PX3, RX7.

On December 2, 2014, Petitioner underwent lumbar and cervical MRI's. The lumbar MRI was stable in appearance when compared to November 2013. It showed: (1) L4-5 postsurgical changes, scar tissue at the right L5 nerve root, right foraminal disc protrusion, and right and left foraminal narrowing; (2) L5-S1 mild to moderate bilateral foraminal narrowing; and (3) L2-3 mild right foraminal narrowing. The cervical MRI was compared to 2012 and it

was noted there was no appreciable change and the cervical spine was stable in appearance. It showed degenerative disc disease with postsurgical changes at C3-4 and C4-5. RX7. Dr. Matz relayed the MRI results to Petitioner by telephone on December 5, 2014, and recommended cervical x-rays to look for instability at C4-5 and C5-6. PX3. Those x-rays were done on December 9 and revealed postoperative changes at C3-4 and C6-7, as well as facet osteoarthritis and uncovertebral arthritis with mild foraminal narrowing at C3-4. PX5, RX7.

On December 10, 2014, Dr. Matz spoke with Petitioner by phone and related the results of the cervical x-rays. He noted Petitioner had a work injury which aggravated her underlying degenerative cervical disc disease and which may have developed a focal C5-6 disc displacement. It was not actively compressing the nerve roots but was creating some slight stenosis at C5-6 with spinal cord compression. He recommended physical therapy and an evaluation by a physiatrist, followed by a functional capacity evaluation to determine her restrictions, if any. Dr. Matz noted Petitioner "had already been through interventional pain management." PX5, RX7.

On January 22, 2015, Petitioner presented to Community Memorial Hospital for a physical therapy evaluation, as ordered by Dr. Matz. She reported she caught a TV that was falling and injured her shoulder and neck. She complained of pain in the right side of her neck and down to her rib cage, and stated it was so intense it caused headaches. It was noted that Petitioner had a history of pain management with little resolve, which indicated the pain was likely chronic. Petitioner participated in physical therapy on January 27 and 29, February 3 and 10. She cancelled the appointment on February 5 due to being ill. A note from April 8, 2015, indicates she failed to return to therapy and was therefore discharged. PX4.

On June 30, 2015, Petitioner was evaluated by Respondent's Section 12 examiner, Dr. Robert Bernardi, spinal neurosurgeon at Olive Surgical Group. She reported she was moving a 50-inch TV when it started to tip over. In trying to stabilize it, her right shoulder was horizontally extended. She reported she had immediate pain in her sternum and right pectoral muscle which extended around the upper part of her chest wall into the right periscapular region. Treatment had consisted of physical therapy, which made her symptoms worse, and medications. She reported she had been off work since May 18, 2014, and that prior to that she had missed days intermittently due to her symptoms. She reported pain in her neck, mid back, chest, and right arm. She stated that elevating her arms or letting them hang at her side without support caused pain in the interscapular and right periscapular regions. The pain extended into her neck and laterally to her axilla and right pectoral muscle and into her sternum. She also reported occasional radiation of pain down her arm and to the thumb. Petitioner reported she had a side job of cutting hair once or twice a week, which also exacerbated her pain. RX1.

Dr. Bernardi reviewed medical records from Anderson Hospital, Dr. Jain, and Dr. Matz, and also reviewed the Associate Incident Report completed by Petitioner. He also reviewed imaging studies of the cervical and thoracic spine areas dating back to 2011. He conducted a physical examination and noted tenderness over the mid and upper thoracic spinous processes with no spasms or trigger points. Range of motion of the cervical spine was 75% of normal in flexion and 50% of normal in extension. Range of motion of the shoulders was full and non-tender. He noted on neurological examination that there may have been weakness in the right

supraspinatus and infraspinatus, which could have been due to guarding as those muscle groups exacerbated Petitioner's periscapular discomfort. RX1.

Dr. Bernardi noted that Petitioner made no reference to symptoms in her lumbar spine or leg and did not mark those areas on the pain diagram she completed that day. He further noted that the first time Petitioner sought treatment for her low back was November 21, 2014, nine months after her accident, when she saw Dr. Matz. He opined that if she was having lumbar problems they were in no way attributable to her work accident of February 19, 2014. He noted Petitioner had neck, right periscapular, right chest, and right arm pain of uncertain etiology. He opined with certainty, however, that her problems were not related to her cervical spine, as the MRI did not show significant nerve root or spinal cord compression, her C6 innervated muscles were normal, there was no diminution of reflexes, and movements that would typically alleviate radicular pain actually aggravated her symptoms. He further opined that Petitioner's accident did not aggravate her pre-existing cervical degenerative disease, for four reasons. First, her cervical MRI of December 2, 2014, revealed no changes when compared to the scans done in 2011 and 2012. Second, she had a long history of neck pain, as noted in the emergency room record following the accident that she was taking Vicodin for her chronic neck and low back problems. Third, aggravations of degenerative disease are typically self-limiting and run their course in a matter of weeks. Fourth, a flare up of arthritis in the neck usually results in neck pain rather than periscapular pain, which is less likely. Dr. Bernardi stated, "I have never seen nor heard of degenerative disc disease referring to the axilla or chest wall". RX1.

Dr. Bernardi did believe, however, that Petitioner sustained some type of injury as a result of the work accident, as the mechanism of injury described by her was one "that could plausibly produce periscapular/chest wall discomfort". He suspected that Petitioner's symptoms represented either a suprascapular or a long thoracic neuropathy, and that the latter was more likely. He recommended an EMG/NCS to test for the presence of either condition and to confirm that her complaints were not radicular. Results of the study would determine what additional testing and/or treatment may be necessary. Dr. Bernardi opined Petitioner was not at maximum medical improvement, pending the study. RX1.

On August 18, 2015, Petitioner underwent the EMG/NCS by Dr. Daniel Phillips of Neurological and Electrodiagnostic Institute. It revealed no evidence of cervical radiculopathy, nor evidence of right suprascapular or long thoracic neuropathy. The study did, incidentally, reveal bilateral carpal tunnel syndrome with left being more prominent. PX6.

On September 1, 2015, Petitioner returned to Dr. Jain with complaints of non-cardiac chest pain for 20 months, as well as fatigue, anxiety, depression, stress, and sleep disturbance. The Arbitrator notes this is the first record from Dr. Jain since June 16, 2014. The physical and neurologic examinations were normal and assessment was right chest wall musculoskeletal pain. Dr. Jain recommended Petitioner have stress reduction and stay off work until seen by a pain management specialist to determine the cause of her chronic pain and the treatment thereof. He completed a Physician Work Status Report that day, indicating Petitioner was unable to work "indefinitely" due to anterior chest pain. PX2.

On September 8, 2015, Dr. Bernardi issued an Addendum after having reviewed the results of the EMG/NCS. He opined that based on the mechanism of Petitioner's injury, her complaints, the imaging studies, and the EMG/NCS, her symptoms should be muscular in nature. He stated, "What is difficult to understand is how a myofascial injury could produce such persistent and significant discomfort. I do not have a good explanation for this." He noted that on December 10, 2014, Dr. Matz recommended physical therapy and evaluation by a physiatrist, possibly followed by work hardening and a functional capacity evaluation. He opined there was not much to be gained with a physiatrist evaluation, but did recommend Petitioner attend four weeks of physical therapy, followed by work hardening if symptoms persisted, followed by return to full duty on a trial basis. If she did not tolerate the return, he recommended a functional capacity evaluation. Dr. Bernardi opined that in the interim, Petitioner could work with restrictions of no lifting more than five pounds with her right arm and no more than 15 pounds with her left arm, avoid overhead activities using the right arm, and be allowed to change positions every 45 minutes to an hour as needed. He believed she should reach maximum medical improvement within eight to twelve weeks, depending on how she responded to the additional treatment recommended. RX2.

On September 29, 2015, Petitioner presented to Dr. Thomas Morrison at Heart Health Specialists for cardiology evaluation. It was noted she had a history of hypertension, hyperlipidemia and palpitations. She reported she was in her usual state of health until April, when she had new chest pain symptoms. She was seen by a cardiologist elsewhere and had a stress test and cath. She reported she had a VF arrest during cath, during injection of the right coronary artery. It was noted she had chest pain and coronary artery disease and continued to have occasional tightness. She also reported, "She recently hurt her chest in catching a large TV from falling. She thinks a lot of her symptoms are related to her injury." Dr. Morrison noted, however, that she had other symptoms with activity and using her arms and shoulders. She reported occasional palpitations, which had improved from previously and were mostly related to caffeine use. Dr. Morrison ordered a lipid panel and pulmonary function test. PX2.

On September 30, 2015, Petitioner presented to Dr. Jain with complaint of right hand pain. She had fullness and a mass in the dorsum of the right forearm which she described as increasing in size and caused radiating pain in her hand. She was referred to an orthopedist for the condition. She also complained of chest wall musculoskeletal pain in the right anterior chest and right axilla, for which she had seen pain specialists and had physical therapy without resolution of symptoms. She was requesting a referral to a different physical therapy facility, which had been recommended by the specialist in St. Louis. Dr. Jain noted that he did not recommend another round of therapy and opined that if a different physician wanted such a referral, they would need to write it. PX2.

On October 12, 2015, Petitioner underwent duplex venous and arterial Doppler studies of bilateral upper extremities, as ordered by Dr. Jain for a one year history of pain in the chest which extended into both arms. Both studies were normal. PX2.

On December 23, 2015, Petitioner presented to chiropractor Mark Eavenson at Multicare Specialists, upon recommendation by her attorney. She reported pain in the center of her chest, mid back, right shoulder, and right arm. She also had a burning in her chest and some neck pain.

She related all of her symptoms to a work injury, which she said occurred when she was pulling a 55-inch TV off the shelf and she fell onto her right side. The Arbitrator notes this is a different history than previously given. She reported her initial pain was in her shoulder and chest. Examination revealed point tenderness directly lateral to the right side at T7-8, and Petitioner stated it was "the exact spot that her pain has been at for a long time". The pain in the mid back was aggravated by range of motion. It was noted Petitioner had no chest pain. Chest x-rays revealed severe degenerative disc disease with hypertrophic spurring in the mid thoracic spine. Petitioner was incidentally found to have bilateral carpal tunnel syndrome. She was referred for a thoracic MRI. PX7.

Petitioner underwent a thoracic MRI on December 28, 2015, which revealed herniations at T6-7 and T7-8, with no stenosis. PX5. She followed up with Dr. Eavenson that same day, who noted the MRI finding of a herniation at T7-8 was consistent with her pain. He ordered physical therapy and referred Petitioner to Dr. Gornet. He also noted Petitioner needed to be referred for her carpal tunnel syndrome, and that she would talk to her attorney to "see if they will agree this is work-related". Petitioner began physical therapy that day with Corey Voss, therapist in Dr. Eavenson's office. The history given of the work accident was somewhat different than that reported to Dr. Eavenson on December 23, that being that as she pulled the TV off the shelf she started to fall on her right side and, as she caught herself, she overextended and twisted, causing pain in her shoulder and chest. PX7.

Petitioner returned to Dr. Eavenson and Mr. Voss on December 29 and 30 2015, and on January 4, 5, 6, 11 and 12, 2016, with varying complaints of pain in the neck, mid back, chest, and right arm, with the primary complaint consistently being to the thoracic area. PX7.

On January 12, 2016, Petitioner presented to Dr. Matthew Gornet of The Orthopedic Center of St. Louis, upon referral by Dr. Eavenson. She completed a pain diagram, indicating on the front she had burning along the right side of her chest and into her right arm to just below the axilla. On the back she indicated she had burning in the neck, down to the right shoulder and right side, and burning in the mid back. She reported to Dr. Gornet that her main complaint was pain at her bra line radiating around to the anterior portion of her abdomen and chest. She also complained of some neck pain and right shoulder and arm symptoms. She related her symptoms to her work accident, which she reported occurred when she was getting a TV that began to fall. She stated she "pulled hard with her right arm to prevent it from falling and had fairly immediate pain". Dr. Gornet indicated he reviewed medical records, though did not give further specificity as to which records other than Dr. Bernardi's. He reviewed Petitioner's MRI of December 28, 2015, and noted herniations at T6-7 and T7-8. He obtained cervical x-rays, which showed solid fusion, and thoracic x-rays, which showed degenerative disc disease particularly on the right. Dr. Gornet opined Petitioner aggravated her preexisting condition in her neck and thoracic spine. He disagreed with Dr. Bernardi that her symptoms were not related to her thoracic spine, and opined her symptoms were "fairly classic" with the pain at the bra line radiating anteriorly around the distribution of the thoracic nerve. He noted Petitioner's subjective complaints correlated fairly well with her MRI findings. He further disagreed with Dr. Bernardi regarding the pathology at C5-6, which he opined could easily refer pain to the anterior chest wall and right arm. He recommended a new MRI and conservative treatment, to consist of steroid injections at

T6-7 and T7-8 and continued care with Dr. Eavenson for at least six weeks. Dr. Gornet believed Petitioner to be temporarily and totally disabled. PX8.

Dr. Gornet testified by way of deposition on March 7, 2016. He is a Board Certified Orthopedic Surgeon. He testified Petitioner provided an oral history of work accident when she pulled a television which began to fall. She pulled hard with her right arm to prevent it from falling and had fairly immediate pain. He did not specify the location of the immediate pain. Dr. Gornet testified consistent with his record. PX9.

Dr. Gornet testified Petitioner's pain could be emanating from her cervical or her thoracic spine or both, as there is often overlap in these areas. He believed her current symptoms and need for treatment were causally connected to her work injury, as the mechanism of pulling or suddenly holding something could put forces on the upper spine, shoulder, and neck, which could cause or contribute to an injury or aggravation of a preexisting condition. PX9.

With regard to treatment, Dr. Gornet believed that therapy and injections would be reasonable for Petitioner's thoracic spine and that there was not a good surgical solution to her thoracic problem. He testified one or two injections and up to three months of therapy and chiropractic manipulation would be appropriate. As to her cervical spine, further treatment could be indicated, including surgery, but Dr. Gornet testified he would hold out on a determination for cervical treatment until Petitioner has received the thoracic injections. Dr. Gornet believed that C5-6 can produce pain referred into the anterior chest and shoulder area, and he disagreed with Dr. Bernardi in that regard. PX9.

On cross-examination, Dr. Gornet acknowledged that he had no independent recollection of Petitioner. He was not aware of any treatment for Petitioner's cervical spine immediately prior to the work accident of February 19, 2014, including the fact that she had been prescribed Hydrocodone for her complaints just before the accident. Dr. Gornet conceded he had not reviewed any of Petitioner's pre-accident MRI studies, and agreed those studies could be helpful in evaluating her cervical condition and determining whether the current findings were new or present prior to the accident. Dr. Gornet was unable to state to a reasonable degree of medical certainty whether Petitioner's symptoms were emanating from her cervical or her thoracic spine. He testified that the most he could say was that he believed her symptoms were coming from one or both of those areas. Dr. Gornet was unaware of whether Petitioner had similar complaints in her chest prior to the work incident. He disagreed with Dr. Bernardi's opinion that it was extraordinarily unlikely that Petitioner aggravated her preexisting cervical spine or thoracic condition. Dr. Gornet acknowledged that Petitioner's EMG study was negative for any type of nerve pain, but testified that often the EMG will fail to reveal any nerve damage and, further, it was possible for Petitioner to have a structural injury to her spine causing neurologic complaints without a positive EMG. PX9.

With regard to Petitioner's work status, Dr. Gornet believed she was temporarily and totally disabled. When questioned whether she could return to a light duty position such as a being a door greeter or answering phones, he testified he wanted to first analyze her conditions and assess her response to treatment. While he believed working light duty was generally beneficial, he did not want to add another variable when attempting to determine Petitioner's

condition and assessment. Once that is established, he would have no problem with her working light duty. PX9.

On March 8, 2016, Petitioner underwent an interlaminar epidural steroid at right T6-7 by Dr. Helen Blake at Orthopedic Ambulatory Surgery Center, as requested by Dr. Gornet. PX10.

On March 21, 2016, Petitioner returned to Dr. Gornet. It was noted she "brought with her other notes from Dr. Matz" but there is no further specificity as to the dates of treatment for those notes. Petitioner reported she had one injection into her thoracic spine, which gave her some relief, and she was scheduled for a second. Prior to seeing Dr. Gornet she had a cervical MRI which, according to radiologist Dr. Greg Cizek, revealed post-op changes at C3-4 and C-7 as well as a moderate sized herniation at C5-6 causing stenosis and bilateral foraminal encroachment where either C6 may be affected. PX5. Dr. Gornet reviewed the MRI and characterized the C5-6 herniation as large, rather than moderate, and indicated the finding correlated with some of Petitioner's anterior chest pain. He noted the finding was also present on the MRI of December 2, 2014. His "working diagnosis" was discogenic neck pain at C4-5 and C5-6, as well as structural mid back pain secondary to a disc injury. Dr. Gornet noted that if Petitioner was not improved after the injections, consideration would be given to disc replacements at C4-5 and C5-6. He noted Petitioner understood there was no good surgical treatment option in her mid back. PX8.

On March 22, 2016, Petitioner underwent a second interlaminar epidural injection at T7-8 by Dr. Blake. She followed up with Dr. Blake on April 6, 2016, and reported that the first injection gave her some pain relief, but that it did not last long. She continued to use Hydrocodone four times a day. She complained of radicular symptoms across her chest wall with aching radiating down her left arm. It was noted a cervical epidural injection had been recommended by Dr. Gornet but had not been scheduled. On examination, Petitioner had diminished range of motion of the cervical spine, tenderness to palpation throughout the cervical paravertebral musculature, and pain with extension of the thoracic spine. Dr. Blake opined Petitioner would benefit from a cervical epidural injection. PX10.

On April 17, 2016, Dr. Bernardi issued a second Addendum report after reviewing additional medial records. Specifically, he reviewed records from Multicare Specialists from December 23, 2015, through January 12, 2016, the MRI films from December 28, 2015, and Dr. Gornet's record of January 12, 2016. With respect to Petitioner's cervical spine, Dr. Bernardi disagreed with Dr. Gornet's contention that Petitioner may have right C6 radiculopathy. In support of his opinion, he referred to his prior report of June 30, 2015. He also noted that the results of Petitioner's EMG/NCS with Dr. Phillips were telling, as they did not reveal any evidence of cervical nerve root irritation. Further, Dr. Phillips' evaluation was notable for non-organic findings, which included stocking-glove sensory loss and demonstrated giveway weakness. Dr. Bernardi found it "interesting" that Dr. Gornet detected weakness in Petitioner's right bicep and deltoid/supraspinatus muscles. He stated, "While these muscles are innervated by C5 and C6, this weakness escaped the detection of two neurosurgeons and a neurologist. I do not know what to make of this." RX3.

With respect to Petitioner's thoracic spine, Dr. Bernardi agreed that the MRI revealed disc herniations at T6-7 and T7-8, however, disagreed that they were responsible for Petitioner's symptoms. He provided several reasons for his opinion. First, he noted that symptomatic thoracic disc herniations were extraordinarily rare and generally occurred in the lower region rather than where Petitioner's pathology was located. Second, asymptomatic thoracic disc disease is extraordinarily common, and for the imaging finding to have any clinical significance, it must correlate with the symptoms. Third, the herniations seen on the diagnostic imaging were centrally located and did not produce significant stenosis that would correlate with Petitioner's symptoms. He highlighted the fact that if Petitioner's central disc herniations were symptomatic, her symptoms would be consistent with midline back pain and situated near the tips of her shoulder blades. Fourth, he disagreed that Petitioner's symptoms were classic for an irritated thoracic nerve root. He noted there was no foraminal stenosis on Petitioner's imaging which would lead to thoracic nerve root irritation. Further, radicular symptoms at this level would radiate around the chest wall in a narrow band-like distribution, rather than what petitioner reported on her symptom diagram with Dr. Gornet on January 12, 2016. Finally, Dr. Bernardi noted that petitioner had a history of thoracic pain predating her work incident. RX3.

Ultimately, Dr. Bernardi indicated that he found it increasingly difficult to attribute any of Petitioner's ongoing complaints to her work activities on February 19, 2014. He opined that, although her mechanism of injury could certainly produce pain, the etiology of her complaints was uncertain. He further opined that Petitioner's complaints were most likely myofascial or muscular in nature. He noted the medical literature suggests that the development of chronic and disabling pain following minor traumatic incidents was primarily driven by non-organic factors. In Petitioner's case, he noted several such non-organic factors: (1) the stocking and glove sensory loss and the giveway weakness detected on Dr. Phillips' exam had no physiological explanation; (2) Petitioner has an attorney on her worker's compensation claim and has pending litigation; (3) Petitioner is over the age of 50; (4) Petitioner has been prescribed narcotics on a monthly basis by her family physician for some time, as documented on the Illinois Prescription Monitoring Program; and (5) Petitioner has a history of chronic neck, thoracic, and low back pain. Dr. Bernardi recommended Petitioner have a functional capacity evaluation, to provide information regarding the need for work restrictions and to give additional insight into the contribution of potential non-organic factors on her perceived disability. RX3.

On April 19, 2016, Petitioner underwent a C5-6 right epidural injection by Dr. Blake, as ordered by Dr. Gornet. RX10. The Arbitrator notes this is the last treatment record submitted.

Dr. Bernardi testified by way of deposition on April 29, 2016. He is a Board Certified Neurosurgeon and focuses his practice on spinal neurosurgery. He examined Petitioner on February 19, 2014. She reported she pulled a TV off a shelf and it began to tip over, which jerked her right arm backward. She complained of pain around her right shoulder blade, referred to as the periscapular region, and in between her shoulder blades. She reported it radiated up into her neck, into her armpit, and around to her chest muscle and sternum, or breastbone. She also reported intermittent tingling and numbness down her right arm to her thumb. RX4.

With regard to her prior medical treatment, Petitioner reported one low back surgery and two neck surgeries. She further reported she had done well after the surgeries and before the

work accident, which Dr. Bernardi found to be inaccurate, as the emergency room record from Anderson Hospital of February 23, 2014, noted she had been taking narcotics (Norco) on a regular basis for neck and low back pain, which would not be necessary if she had been doing well. Based on that, Dr. Bernardi concluded Petitioner had some residual or ongoing symptoms at the time she was hurt. RX4.

As part of his examination, Dr. Bernardi had Petitioner complete a pain disability questionnaire. He noted that very elevated scores on the questionnaire predict that a person is not going to respond particularly well to treatment aimed at their symptoms. Petitioner did not answer all of the questions, 15 out of 20, but her score on those 15 questions was high. The Arbitrator notes that the questionnaire was not attached to Dr. Bernardi's original report, but was included as Respondent's Deposition Exhibit 2 by agreement of the parties, as was the patient intake form and pain diagram completed by Petitioner on June 30, 2015. RX4.

Dr. Bernardi reviewed cervical MRI scans from both before and after the accident, and found no new acute findings after the accident. His clinical assessment, from her history and physical examination, also led him to conclude there were no new acute findings. With regard to the physical examination, he noted Petitioner had some limitation in the range of motion of her neck, which was mild considering her previous fusions and current body habitus, and had some tenderness over the thoracic spine region. Otherwise, her physical exam was unremarkable, her neurologic exam was normal, her reflexes were symmetric, and there was no weakness detected. Dr. Bernardi testified there was some question about weakness in two muscles around the right shoulder, but it was difficult to know whether it was genuine weakness or related to pain associated with testing the muscles. He noted both Dr. Matz and Dr. Phillips conducted similar testing and did not find any evidence of weakness in those areas. Dr. Bernardi testified that different peripheral nerves and different nerve roots supply different muscles, and assessing weakness helps to diagnose what might be responsible for a patient's complaints. Weakness in certain muscles, in a certain pattern will tend to implicate different nerve roots or different peripheral nerves. RX4.

Dr. Bernardi testified that Petitioner's subjective complaints did not correlate with her imaging findings, and he was confident her symptoms were not related to either her neck or her thoracic spine. Specifically, her clinical presentation was not consistent with either thoracic myelopathy or thoracic radiculopathy and Petitioner did not have any pain complaints referable to her thoracic spine until several months after her accident. With regard to her neck, she has a history of chronic neck pain and there was no evidence of skeletal or ligamentous injury or irritated nerve root. Dr. Bernardi testified that in looking at Petitioner's serial MRI's there has been no progression of her degenerative disease. Most individuals with an aggravation of degeneration complain primarily of pain in the neck itself, whereas Petitioner's chief complaint has been pain around the shoulder blade and in her chest. RX4.

Dr. Bernardi testified that he initially considered Petitioner could have long thoracic or suprascapular neuropathy, given her complaints and the mechanism of injury, and so recommended an EMG/NCS to evaluate. The studies were negative, other than the incidental finding of bilateral carpal tunnel syndrome, and revealed no evidence of long thoracic or suprascapular neuropathy, or cervical or thoracic radiculopathy. He addressed Dr. Gornet's

testimony that an EMG/NCS study would only be positive if there was significant irritation of the nerve. He agreed that no test is perfect, which is why its results are viewed in constellation with other things. As to Petitioner, neither her history nor her exam was consistent with radiculopathy, and her MRI did not show any stenosis. With the EMG also showing no evidence of radiculopathy, the total of the factors led to his conclusion. Dr. Bernardi testified that the EMG, if anything, is too sensitive and can show problems that have no clinical relevance, such as Petitioner's finding of bilateral carpal tunnel syndrome without any symptoms of the condition. RX4.

Ultimately, Dr. Bernardi concluded that the most logical explanation for Petitioner's condition is that she simply suffered a myofascial/muscular strain. He found the duration and severity of her continued complaints to be inexplicable given this diagnosis. However, he highlighted the fact that medical literature often showed the development of chronic symptoms due to minor trauma can be due to non-physiological or non-organic factors, which he suspected was the case with Petitioner. He noted there were several red flags which would support such a conclusion, which included: (1) Petitioner was not forthright about her prior history to Dr. Bernardi; (2) she was seeking disability and inquired with her family doctor early in the process about disability; (3) her age; (4) the lack of any objective signs of trauma on imaging and lack of objective abnormalities on examination; and (5) non-organic physical exam findings such as stocking and glove sensory loss and give way weakness with no physiological explanation. Dr. Bernardi noted that both physical exam findings of stocking and glove sensory loss and give way weakness would suggest less than full effort as they are non-organic findings. Finally, Dr. Bernardi noted that Petitioner's scores on the psychological testing he performed in his office were consistent with non-physiological factors playing a role in her condition. RX4.

Based on these considerations, Dr. Bernardi believed the only additional treatment that would be warranted at the time of his 9/8/15 report would be physical therapy or work conditioning with the hopes of returning Petitioner to work full duty. Although he did not believe it would be unreasonable for Petitioner to have work restrictions, given her subjective complaints, he did not believe there was any objective basis warranting same. RX4.

Dr. Bernardi prepared a final addendum report on April 17, 2016 after reviewing medical records from Dr. Gornet, Dr. Eavenson and Mr. Voss, and an MRI of the thoracic spine dated December 28, 2015. He did not believe that any of the findings on the thoracic MRI supported a diagnosis of thoracic radiculopathy. Although he agreed there was a herniation, he noted there was no stenosis present. He also disagreed with Dr. Gornet's conclusion that Petitioner's symptoms were classic for thoracic radiculopathy. In support of his opinion, he noted that thoracic radiculopathy was extraordinarily rare, and he usually only saw such cases about once per year. On the other hand, it was extraordinarily common for individuals to have findings such as Petitioner's without any complaints in the thoracic spine. This led him to believe that there was no structural abnormality in the thoracic spine which was causing Petitioner's symptoms. Perhaps most significantly, Dr. Bernardi noted that if Petitioner's symptoms were in fact radiating from the thoracic spine she would have localized mid-back pain radiating in a very specific pattern around her chest wall in a narrow band. However, Petitioner's complaints were simply not consistent with this presentation, as they were diffuse in nature. RX4.

Dr. Bernardi further disagreed with Dr. Gornet's contention that Petitioner's cervical pain was due to a disc injury at C5-6. Her physical exam findings, diagnostic imaging, EMG/NCS study, and subjective complaints of pain all failed to reveal any objective basis for concluding a C6-7 disc injury was involved. Although he acknowledged that Petitioner's arm pain did follow a C6 distribution, he noted there were a number of other factors that could explain her pain. Therefore, in the absence of any objective findings, he would be hesitant to conclude that any cervical radiculopathy was responsible for Petitioner's complaints. RX4.

Given the complete lack of objective findings supporting Dr. Gornet's diagnosis, Dr. Bernardi believed that Petitioner could be considered at maximum medical improvement. He recommended a functional capacity evaluation to determine the need for work restrictions and evaluate potential non-organic factors contributing to Petitioner's complaints. He disagreed with Dr. Gornet's recommendation for thoracic spine or cervical spine injections or surgical intervention, noting medical literature did not support use of injections or surgery for spine pain that was not associated with neurological features. RX4.

On cross examination, Dr. Bernardi acknowledged that he initially indicated that Petitioner was a credible historian during his June 30, 2015, IME. However, he noted that he later discovered that she was not entirely forthright about the nature of her complaints leading up to the incident. Dr. Bernardi also acknowledged that Petitioner's alleged mechanism of injury could have produced an aggravation of the thoracic or cervical spine. However, he reiterated that was extremely unlikely given the complete lack of objective findings. Finally, Dr. Bernardi agreed that he was unable to come to any specific diagnosis regarding Petitioner's thoracic or cervical spine. RX4.

CONCLUSIONS OF LAW

The Arbitrator hereby incorporates by reference the above Findings of Fact, and the Arbitrator's and parties' exhibits are made part of the Commission's file. After review of the evidence and due deliberations, 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 which arose out of and in the course of Petitioner's employment by Respondent, the Arbitrator finds the following:

The Arbitrator finds that Petitioner has met her burden of proof in establishing that an accident occurred which arose out of and in the course of her employment. In so concluding, the Arbitrator finds significant that Petitioner's testimony concerning the facts of the occurrence was unrebutted by Respondent.

In support of the Arbitrator's decision relating to issue (F), whether Petitioner's current condition of ill-being is causally related to the injury, the Arbitrator finds the following:

A claimant has the burden of proving by a preponderance of the credible evidence all elements of the claim, including that any alleged state of ill-being was caused by a workplace accident. *Parro v. Industrial Commission*, 260 Ill.App.3d 551, 553 (1st Dist. 1994). Liability cannot be premised upon imagination, speculation, or conjecture, but must arise from facts established by a preponderance of the evidence. *Illinois Bell Tel. Co. v. Industrial Comm'n*, 265 Ill.App.3d 681, 685 (1st Dist. 1994).

It has long been recognized that, in preexisting condition cases, recovery will depend on the employee's ability to show that the work-related accidental injury aggravated or accelerated the preexisting disease, such that the employee's current condition of ill-being can be said to have been causally connected to the work injury and not simply the result of a normal degenerative process of the preexisting condition. *Sisbro, Inc. v. Industrial Commission*, 207 Ill.2d 193, 204-206 (2003). The existence of health problems of an employee prior to a work-related injury neither deprives the employee of a right to benefits nor relieves the employee of the burden of proving a causal connection between the employment and the subsequent health problems. *Neal v. Industrial Comm'n*, 141 Ill.App.3d 289, 296 (1st Dist. 1986).

The Arbitrator finds that Petitioner has failed to prove by a preponderance of the evidence that her current complaints with regard to her chest, abdomen, right shoulder, right arm, cervical, thoracic and low back, and any other body part are causally related to her work accident of February 19, 2014. In so concluding, the Arbitrator finds significant the changes in Petitioner's reported accident history and complaints and the chronology of treatment, Petitioner's credibility, and the medical records and opinions expressed by various providers.

The medical records clearly establish Petitioner had a longstanding history of prior cervical, thoracic, and lumbar problems, for which she had undergone three surgeries. She also had prior complaints of pain down her arms, between her shoulder blades, around her ribcage, and in the periscapular area.

Reported accident history and complaints and chronology of treatment

The first history of the accident and resulting complaints was in the emergency room at Anderson Hospital on February 23, 2014. Petitioner reported she had to catch a heavy TV that jerked her arm and she thought she pulled a muscle in her chest. Her only complaint at that time was sharp pain in her right upper chest and upper abdomen. The Arbitrator notes and finds significant that Petitioner reported that she took Vicodin for chronic neck and back pain. The discharge diagnosis was musculoskeletal right chest pain, the same diagnosis later made by Dr. Bernardi. When Petitioner completed the Associate Incident Report, she reported the same accident history, and reported her injury as a pulled muscle, right side of chest and arm.

Although Dr. Jain's initial medical record of February 28, 2014, inexplicably did not contain a full history, Petitioner's complaint was the same as it had been in the ER, that being right anterior chest pain radiating into the right axilla. Dr. Jain's diagnosis was musculoskeletal right chest pain, the same diagnosis later made by Dr. Bernardi.

Petitioner's complaints remained consistent when she saw Dr. Jain on March 28, April 25, and May 9, and when she saw Nurse Practitioner Darr on May 19. On May 19 she reported her chest was "burning" and she wanted off work. There were no other complaints voiced at that time. NP Darr took off her off work and instructed her to follow up in three weeks. However, Petitioner advised she could not return for four weeks, as she was going on vacation.

When Petitioner returned to Dr. Jain on June 16, 2014, her complaints had drastically changed. Dr. Jain stated, "Now she is complaining of mid thoracic pain which radiates to right chest wall in a radicular pattern." He went on to note, "I have explained to her that it is difficult for me to state definitely whether her work related injury is causative or contributory to current pain or if this is recurrence of her previous pain." The Arbitrator finds this change in complaints, and Dr. Jain's comments and opinion regarding same, to be quite telling. Dr. Jain wanted her to return to Dr. Matz, who previously treated her for her cervical, thoracic, and lumbar issues.

Petitioner did not seek treatment again until November 21, 2014, some **23 weeks** later. She testified, and Dr. Jain's June 16 record noted, that she was scheduled to have surgery for an unrelated issue, would be off work for six weeks, and would not be able to see Dr. Matz until after that time. Though a delay of six weeks might be understandable, the Arbitrator finds this 23 week gap in treatment to be substantial and nearly insurmountable. In addition to the gap in time, Petitioner reported yet another new and different history of the work accident and resulting injury. She reported to Dr. Matz, "She was lifting a 55-inch TV that fell on her right shoulder. Thereafter, she noted some pain located in her right shoulder associated with fatigue in her right arm. She also noted some incidental fatigue in the right leg." Her symptoms that day were neck pain, fatigue in the right arm and leg, and low back pain. Not only did the mechanism of accident change, but Petitioner's symptoms changed yet again. In fact, there is no mention of pain in her chest, ribs, or abdomen, or even in the thoracic area.

When Dr. Matz spoke with Petitioner by phone on December 10, 2014, he advised her she had a work-related injury which aggravated her underlying degenerative cervical disc disease. The Arbitrator finds significant that Dr. Matz's purported causal opinion is based upon an inaccurate history of the accident and resultant symptoms, as reported by Petitioner.

When Petitioner saw Dr. Bernardi on June 30, 2015, she reported she was moving a TV which started to tip over and she tried to stabilize it but her right shoulder horizontally extended in the process. This is essentially the same history as the original report to the emergency room and her employer. However, Petitioner also reported to Dr. Bernardi that she had immediate pain in not only her sternum and chest, but also in her right periscapular region, which was not accurate. In fact, she did not report any pain in or around her shoulder until November 21, 2014, nine months after the accident. This was also after a nearly six month gap with no medical treatment, which the Arbitrator finds significant.

There was yet another gap in treatment following that. When Petitioner returned to Dr. Jain on September 1, 2015, she had not seen a treating physician since Dr. Matz on November 21, 2014, a ten month gap. She had not undergone any medical treatment since her physical therapy appointment on February 10, 2015, a seven month gap. It was noted at that time that Petitioner had unrelated issues of anxiety, depression, stress, and sleep disturbance. Dr. Jain,

without discussion or explanation in his note, stated Petitioner needed "stress reduction" and should stay off work until seen by a pain management specialist. The Work Status Report completed that day originally noted Petitioner was unable to work "9-2-15 till forever". It was amended by crossing out "forever" and writing in "indefinitely". The Arbitrator finds the above-mentioned gap in treatment to be significant, and finds Dr. Jain's unexplained off work slip to be quite strange.

Petitioner gave two additional accident histories, and her symptoms changed yet again, when she saw Dr. Eavenson on December 23, 2015, and Physical Therapist Voss on December 28, 2015. She told Dr. Eavenson she was pulling a TV off the shelf and fell onto her right side and had pain in her shoulder and chest. Her primary complaint that day was pain in the mid back. She told Mr. Voss, five days later, that she pulled a TV off the shelf, started to fall on her right side, caught herself, and overextended and twisted. Not only are these histories different from each other, they are also different from the original history given after the accident and for the first four months of treatment.

Petitioner's credibility

It is the function of the Commission to judge the credibility of the witnesses and to resolve conflicts in the medical testimony. *Caterpillar Tractor Co. v. Industrial Comm'n*, 124 Ill.App.3d 650, 653 (4th Dist. 1984). Testimony under oath and subject to cross-examination is the benchmark of credibility. *Chicago Messenger Service v Industrial Comm'n*, 356 Ill.App.3d 843, 850 (1st Dist. 2005).

There are significant issues as to Petitioner's credibility, the first of which is her inconsistent history of the accident and resulting injuries, as detailed above. In addition, Petitioner was impeached on several points during her testimony. She testified that her pre-accident complaints were different than her post-accident complaints, when in fact they were nearly identical, as pointed out with Dr. Matz's note of May 15, 2012, on cross-examination.

Petitioner's attempt to minimize the extent of her pre-accident complaints during her initial evaluation with Dr. Bernardi is also concerning. She specifically denied any significant pain immediately prior to the accident. However, Dr. Bernardi discovered, both in the emergency room record and the Illinois Prescription Monitoring Program, that Petitioner had been prescribed Norco for her pain complaints all the way up until the work accident. This strongly suggests that Petitioner's pre-accident complaints were more severe than she reported.

With regard to the work accident, Petitioner conceded on cross-examination that following the accident her symptoms were only to the right chest, upper abdomen, and right arm, and that she made no report of any neck or back complaints until June 16, 2014, four months later. She did not recall Dr. Jain informing her he was unable to state whether her work injury caused her thoracic pain, due to her prior problems, but she did not dispute his records. Despite the lack of documentation in the medical records, and Dr. Jain's inability to causally relate her complaints, Petitioner maintained she had experienced similar and consistent complaints of pain since the date of the accident. The Arbitrator finds Petitioner's testimony to be unreliable in the face of the unbiased medical records and her own statements immediately following the accident.

Petitioner attempted to explain that she stopped treating with Dr. Matz because he told her he would not see a worker's compensation case. His records, however, do not corroborate that any such conversation took place, nor do they give any indication that he would no longer treat her for that reason. She also attempted to explain that she stopped attending physical therapy ordered by Dr. Matz because it caused severe headaches. The therapy records, however, document no such complaints of severe headaches.

When viewing the record as a whole, the Arbitrator finds Petitioner to be lacking in credibility with regard to her complaints as they relate to her work accident.

The medical records and opinions expressed by various providers

As discussed above, Dr. Jain recognized on June 16, 2014, that Petitioner's complaints and symptoms had changed substantially on that date, as compared to immediately after the accident and the four months following. He could not say that the new symptoms were causally related. The Arbitrator finds significant and is persuaded by Dr. Jain's opinion in this regard. Dr. Matz and Dr. Eavenson based their causal opinions on an inaccurate history of the accident and on symptoms which did not exist until many months after the accident. The Arbitrator finds these causation opinions to not be credible or persuasive.

The Arbitrator further finds Dr. Bernardi's opinion that Petitioner simply suffered a chest wall strain to be more credible and persuasive than that of Dr. Gornet. It is clear, in light of the discussion above, that Petitioner's history of the accident and injury changed throughout her treatment. Dr. Gornet relied upon an inaccurate understanding of Petitioner's initial complaints following the accident. The Arbitrator finds significant that in his initial note, and in his testimony, Dr. Gornet stated that following the accident Petitioner had "immediate pain", yet he did not specify in any way the *location* of the pain at that time. In addition, although he testified that Petitioner aggravated her pre-existing cervical and thoracic conditions, his testimony was equivocal at best. He was unable to state to a reasonable degree of medical certainty whether Petitioner's symptoms were emanating from her cervical or thoracic spine, and could only state that he believed they were coming for one or both of the areas. Further, Dr. Gornet did not have the opportunity to review any of Petitioner's pre-accident medical records or diagnostic imaging. He acknowledged on cross-examination that comparing the pre-accident imaging to the post-accident imaging could affect his opinion.

In contrast, Dr. Bernardi was able to confidently state that Petitioner's symptoms were not coming from either the thoracic or the cervical spine. He provided a detailed explanation as to why Petitioner's objective findings and subjective complaints did not correlate with either a cervical or thoracic condition. He also had the opportunity to compare Petitioner's pre-accident diagnostic imaging with her post-accident imaging, and was unable to detect any post-accident changes in the spine.

Dr. Bernardi's opinion carries additional credibility, as he ruled out other potential causes of Petitioner's symptoms prior to concluding that she simply suffered a chest wall strain. Specifically, he recommended an EMG/NCV testing to evaluate potential suprascapular or long

thoracic neuropathy. It was only after the results came back negative that he provided his ultimate opinion.

The Arbitrator notes that although some deference is typically given to the treating physician, such deference is not warranted here. This is due to the fact that Dr. Bernardi had an accurate understanding of the history of the accident and injury. In contrast, Dr. Gornet's first evaluation was not until January 12, 2016, almost two years after the accident, and his opinion was based on an inaccurate history.

Based on the foregoing and the record in its entirety, the Arbitrator concludes that Petitioner failed to prove by a preponderance of the evidence that her current condition of ill-being and need for treatment are causally related to her work accident of February 19, 2014. The Arbitrator further finds that Petitioner reached maximum medical improvement on June 16, 2014, that being the day that Petitioner's symptoms dramatically changed, and that being the last treatment before a gap of 23 weeks. The Arbitrator is mindful that Dr. Bernardi did not examine Petitioner until June 30, 2015. However, the record is very clear with regard to the change in Petitioner's complaints on June 16, 2014, the 23 week gap in treatment thereafter, the subsequent changes in her accident history and complaints, and the medical opinions given in reliance upon an inaccurate history.

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, 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 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).

In light of the Arbitrator's findings with respect to issue (F), the Arbitrator finds that medical services rendered from February 23, 2014, through June 16, 2014, were reasonable and necessary in Petitioner's care and treatment relative to her accident of February 19, 2014. Having reviewed the medical bills set forth in Petitioner's Exhibit 11, the Arbitrator finds that Respondent is not liable for any of these outstanding medical bills, as they were all incurred subsequent to June 16, 2014.

In support of the Arbitrator's decision relating to issue (K), Petitioner's entitlement to prospective medical care, the Arbitrator finds the following:

In light of the Arbitrator's finding above with respect to issue (F), the Arbitrator finds that Petitioner is not entitled to ongoing medical care. With regard to a Functional Capacity Evaluation, mentioned in the medical records, the Arbitrator finds that same is not warranted. Petitioner was not restricted from her normal job due to her chest wall contusion after June 16,

2014. Any restriction or limitation after that date would not be related to her work accident of February 19, 2014.

In support of the Arbitrator's decision relating to issue (L), Petitioner's entitlement to temporary total disability, the Arbitrator finds the following:

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits for two periods of time.

1. April 25, 2014, through May 9, 2014, a period of 2 1/7 weeks. In so concluding, the Arbitrator notes that on April 25, 2014, Dr. Jain authorized Petitioner to be "off work for 3-4 weeks". When she returned to Dr. Jain on May 9, 2014, he indicated she could work "only sitting job with no lifting for 6 weeks". In that Respondent provided accommodated work, Petitioner is not entitled to TTD after May 9, 2014.
2. May 19, 2014, through June 16, 2014, a period of 4 1/7 weeks. In so concluding, the Arbitrator notes that on May 19, 2014, NP Darr authorized Petitioner to be off work until seen by Dr. Jain on June 16, 2014. Dr. Jain did not provide a further off work authorization at that time.

For all other periods of time between February 19, 2014, and June 16, 2014, Petitioner was allowed to work with various restrictions and is therefore not entitled to temporary total disability benefits.

The Arbitrator finds that Petitioner is entitled to temporary total disability benefits for a total of 6 2/7 weeks. The parties stipulated that Petitioner's average weekly wage was $428.43, and the Arbitrator finds Petitioner's temporary total disability rate is $285.62. Respondent is liable for temporary total disability benefits of $1,795.33, and is entitled to credit for $693.67 previously paid.

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

David Schultz,
Petitioner,

vs.

NO: 14 WC 36169

17IWCC0513

SOI/Southern Illinois University Carbondale,
Respondent.

DECISION AND OPINION ON REVIEW

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

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed October 13, 2016 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 required for State of Illinois cases.

DATED: AUG 18 2017

L. Elizabeth Coppoletti

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mas
o:8/2/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHULTZ, DAVID
Employee/Petitioner

Case# **14WC036169**

17IWCC0513

SOI/SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
Employer/Respondent

On 10/13/2016, 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 0.49% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1413 BRAD L BADGLEY PC
26 PUBLIC SQUARE
BELLEVILLE, IL 62220

0499 DEPT CENTRAL MANAGEMENT SERV
WORKERS' COMPENSATION MANGER
PO BOX 19208
SPRINGFIELD, IL 62794-9208

0558 ASSISTANT ATTORNEY GENERAL
NICOLE M WERNER
601 S UNIVERSITY AV SUITE 102
CARBONDALE, IL 62901

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

0904 STATE UNIVERSITY RETIREMT SYS
PO BOX 2710 STATION A
CHAMPAIGN, IL 61825

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

OCT 13 2016

DONALD A. RASPANTI, ASSISTANT SECRETARY
Illinois Workers' Compensation Commission

17IWCC0513

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 Schultz
Employee/Petitioner

v.

SOI/Southern Illinois University Carbondale
Employer/Respondent

Case # 14 WC 036169

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 **Nowak**, Arbitrator of the Commission, in the city of **Herrin**, on **October 15, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0513

FINDINGS

On **April 2, 2014**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$67,413.56**; the average weekly wage was **$1,296.41**.

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

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

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services of $12,434.5, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $864.27/week for 7 weeks, commencing 10/3/14 through 11/20/14, as provided in Section 8(b) of the Act.

Based on the factors enumerated in §8.1b of the Act, which the Arbitrator addressed in the attached findings of fact and conclusions of law, and the record taken as a whole, Respondent shall pay Petitioner the sum of **$721.66**/week for **19** weeks, as provided in Section **8(e)** of the Act, because the injuries sustained caused **10% loss of the right hand.**

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.

Michael K. Nowak, Arbitrator

9/9/16
Date

OCT 13 2016

FINDINGS OF FACT

Petitioner is 59 years old and has been employed as a locksmith for Southern Illinois University Carbondale for fifteen years. Petitioner alleged that he suffered repetitive trauma to his right hand due to his job duties with a manifestation date of April 2, 2014. Petitioner testified that his primary duties are cutting keys and pinning and installing cores.

Respondent's exhibit 6 is a Key Control Count document prepared by Elizabeth Hastings. (RX6). This document indicates that two employees produce 10,600 keys annually. This equates 5,300 keys produced annually by each employee, or approximately 100 per week. The Key Control Count indicates the two employees perform 2,080 repins annually. which equates to 1,040 repins performed annually by each employee, or approximately 20 per week. The Key Control Count indicates the two employees produce 2,000 fobs annually, or approximately 20 per week. The Key Control Count indicates the two employees performed 1,144 re-cores annually, or approximately 11 per week.

Petitioner testified that the Key Control Count document was accurate. Petitioner testified that when cutting keys, he has to move a lever eight times to cut the key. On cross-examination, Petitioner testified that it takes approximately 20 seconds to produce a key, five minutes to perform a re-pin, five to 10 minutes to type in a fob, and about a half hour to perform a re-core. Petitioner testified that he does not make the fobs, they come already made and he programs them. Petitioner testified that there are two locksmiths employed for Respondent.

Petitioner testified that he saw Dr. Sawar on April 2, 2014 for numbness in his hands. Petitioner testified that he had seen his primary doctor for that problem prior to that time. Petitioner admitted that he had seen his primary doctor on three different occasions complaining of problems in his hands the year prior to seeing Dr. Sawar and that he believed the problems were related to his job duties at that time. Petitioner testified that he filled out a Notice of Injury in September 2014, but had told his foreman, David Bryant, about the problem with his hands prior to that time.

On April 2, 2014, Petitioner presented to Dr. Sawar at Neurology & Arthritis Clinic complaining of numbness and tingling in his right hand for the past six months. (PX4). Petitioner indicated that his symptoms were aggravated by driving and woke him at night. (PX4). Petitioner gave a history of psoriasis, arthritis, back injury, and dyslipidemia. (PX4). Dr. Sawar performed a nerve conduction study and an EMG. (PX4). The impressions were: 1) moderately severe right median mononeuropathy at the wrist (i.e. carpal tunnel syndrome) without active denervation and 2) mild left median mononeuropathy at the wrist without denervation; there was no electrodiagnostic evidence of ulnar mononeuropathy or cervical radiculopathy. (PX4). Dr. Sawar referred Petitioner to Dr. Young.

On September 10, 2014, Petitioner filled out a Patient Intake Questionnaire for the Orthopaedic Institute of Southern Illinois in which he indicated that he had numbness in his right hand since July. (PX1b). Petitioner also indicated on this form that this was a workers' compensation claim and that punching keys made his symptoms worse. (PX1b). Petitioner indicated that he had hypertension, elevated cholesterol, lung disease, arthritis, and other orthopedic conditions, as well. (PX1b). Petitioner also indicated that his hobbies were hunting and riding motorcycles. (PX1b).

On September 10, 2014, an Illinois Form 45: Employer's First Report of Injury was prepared which indicated that the date of injury was July 15, 2014 and that the injury was caused by repetitive motion. (RX1). On that same date 2014, Petitioner filled out a Workers' Compensation Employee's Notice of Injury form. (RX2). Petitioner indicated that the date of injury was April 2, 2014. (RX2). Petitioner indicated that he reported his injury to his supervisor on July 15, 2014. (RX2). Petitioner indicated that he felt pain in hand after capping cores and pushing on the press. (RX2). Petitioner's supervisor, David Brandt, appeared at the hearing as Respondent's representative, but did not testify. He did, however prepare a "Witness Statement" which is a part of the Supervisor's First Report of Injury. (PX7, p. 2) Mr. Brandt's statement describes the physical demands of rekeying locks. It also indicates the incident occurred on April 2, 2014.

On September 23, 2014, Petitioner presented to Dr. Steven Young at the Orthopaedic Institute of Southern Illinois. (PX1b). Petitioner complained of bilateral hand numbness and pain for several months, right worse than left. (PX1b). Dr. Young reviewed the nerve conduction study and performed a physical examination of Petitioner. (PX1b). Dr. Young diagnosed Petitioner with bilateral carpal tunnel syndrome and recommended Petitioner undergo a right carpal tunnel release. (PX1b). On October 3, 2014, Petitioner underwent a right carpal tunnel release by Dr. Young. (PX1b). Petitioner tolerated the procedure well. (PX1b). On October 17, 2014, Petitioner followed up with Dr. Young. (PX1b). Petitioner indicated that he was doing well with no complaints. (PX1b). Petitioner's sutures were removed. (PX1b). Petitioner was to follow up in one month. (PX1b). On November 20, 2014, Petitioner followed up with Dr. Young. (PX1b). Petitioner indicated that his numbness and tingling in his right hand had resolved and he was very happy with his surgery. (PX1b). Petitioner was released from Dr. Young's care for his right hand. (PX1b).

Petitioner testified that he provided locksmith services outside of SIU-C. Petitioner testified that he does not keep track of how many calls he gets, but he may get 10 in a week. Petitioner testified that he is paid for his locksmith services that he performs outside of his employment with Respondent. Petitioner testified that his hobbies included hunting, fishing, and riding his motorcycle. Petitioner testified that he both shotgun and bow hunted deer and harvested a deer in the 2014 season. Petitioner testified that he rides his motorcycle to and from work and uses it as his source of transportation. Petitioner testified that he has been riding motorcycles for 40 years.

On March 27, 2015, Petitioner underwent a Section 12 examination with Dr. Anthony Sudekum. (RX7). Dr. Sudekum performed a physical examination, reviewed Petitioner's medical records, and took a verbal history from Petitioner. (RX7). Dr. Sudekum noted Petitioner has been employed with Respondent for approximately 15 years as a locksmith. (RX7). Dr. Sudekum noted that he reviewed Petitioner's medical records which indicated Petitioner had treated for multiple chronic conditions including rheumatoid arthritis, osteoarthritis, gout upper and lower extremity, peripheral neuropathies, hypertension, peripheral edema, leg cramps, muscle spasms, myalgias, psoriasis, abdominal pain, dermatosis, gastroesophageal reflux disease, and hyperlipidemia. (RX7). Dr. Sudekum noted Petitioner falls into the obese body morphology category. (RX7). Dr. Sudekum noted that he also reviewed the Key Control Count document by Elizabeth Hasting and four videos supplied by Petitioner which showed Petitioner performing his job duties at work, including key fabrication, key stamping, re-pinning locks, and re-coring locks. (RX7). Dr. Sudekum opined that Petitioner's job duties for Respondent did not cause or aggravate right or left carpal tunnel syndrome or result in Petitioner's need to undergo medical and/or surgical treatment for those conditions. (RX7).

Petitioner testified that he underwent a right carpal tunnel release and was off of work from October 3, 2014 until November 20, 2014, at which time he was released to return to work full duty. Petitioner testified that he returned to work on November 20, 2014 full duty and that he is still performing the same job as a locksmith. Petitioner testified that he does not take any medications for his right hand, nor does he wear any brace or protective device. Petitioner testified that he is able to perform his job satisfactorily and that he has never received any complaints from his supervisors.

Dr. Steven Young testified via evidence deposition on August 25, 2015. (PX1). Dr. Young testified that Petitioner's chief complaint was numbness in the right and left hands. (PX1, pg. 8). Dr. Young testified that Petitioner indicated that punching keys made his symptoms worse and that he would cut keys 20 to 70 percent of his workday. (PX1, pg. 9). Dr. Young testified that he performed a physical examination and reviewed a nerve conduction study and diagnosed Petitioner with severe right carpal tunnel syndrome and mild left carpal tunnel syndrome. (PX1, pg. 10-11). Dr. Young testified that he recommended and performed a right carpal tunnel release. (PX1, pg. 11). Dr. Young testified that he reviewed videotapes of Petitioner performing his job activities as well as a hand questionnaire Petitioner filled out regarding job duties he performed prior to his deposition. (PX1, pg. 12). Dr. Young testified that based on Petitioner's history and the physical examination of Petitioner; he believed Petitioner's job duties caused his diagnosis of bilateral carpal tunnel syndrome. (PX1, pg. 12). Dr. Young testified Petitioner tolerated the right carpal tunnel release well and was released at maximum medical improvement on November 20, 2014. (PX1, pg. 13-14). Dr. Young testified that Petitioner did not suffer any functional impairment by reason of the condition of his right hand. (PX1, pg. 14). Dr. Young testified that hypertension and psoriatic arthritis can also contribute to carpal tunnel syndrome. (PX1, pg. 20). Dr. Young testified that Petitioner's elevate BMI and age could also be risk factors in the development of carpal tunnel syndrome. (PX1, pg. 20-21).

Dr. Anthony Sudekum testified via evidence deposition on October 8, 2015. (RX8). Dr. Sudekum testified that Petitioner had been diagnosed with atherosclerotic vascular disease and that anyone who has atherosclerotic disease also has an increased tendency to develop carpal tunnel syndrome because of its effect on the peripheral vascular feeding of the blood to the median nerve in the wrist and palm. (RX8, pg. 19). Dr. Sudekum testified that he diagnosed Petitioner with right carpal tunnel syndrome, resolved through successful surgical intervention. (RX8, pg. 25). Dr. Sudekum testified that Petitioner did not have left carpal tunnel syndrome. (RX8, pg. 25). Dr. Sudekum testified that Petitioner had multiple diagnoses that would be considered risk factors for the development of carpal tunnel syndrome, including: osteoarthritis, rheumatoid arthritis, psoriatic arthritis, hyperglycemia, peripheral edema, hypertension, hyperlipidemia, and cervical radiculopathy. (RX8, pg. 26-27). Dr. Sudekum also testified that Petitioner's age and elevated BMI would be risk factors in the development of carpal tunnel syndrome. (RX8, pg. 27-28). Dr. Sudekum also testified that Petitioner's hobbies of riding a motorcycle, hunting, and fishing can also contribute to the development of carpal tunnel syndrome. (RX8, pg. 28). Dr. Sudekum testified that he took a history from Petitioner regarding his job duties, reviewed a Key Control Count document from Elizabeth Hastings, and also reviewed videos (PX5) of Petitioner performing his job duties. (RX8, pg. 30). Dr. Sudekum testified that based on his review of the medical records, the history taken from Petitioner, and the videos and other documentation he reviewed, Petitioner's job duties did not cause or contribute to Petitioner's development of carpal tunnel syndrome. (RX8, pg. 32-33). Dr. Sudekum testified that Petitioner's comorbid medical pathology as well as his comorbid conditions were causative of Petitioner's carpal tunnel syndrome, regardless of his employment activities. (PX8, pg. 33-34). Dr. Sudekum further testified

that Petitioner's job duties were mild to moderate in terms of manual activities and that those tasks were performed at a relatively low frequency based on an eight hour work day. (RX8, pg. 33-34). Dr. Sudekum testified that Petitioner's job duties did not make a difference in Petitioner's development of his carpal tunnel pathology and his need for surgical treatment. (RX8, pg. 35).

The Arbitrator notes that Dr. Sudekum's assertion that Petitioner's job duties were mild to moderate in terms of manual activities is contradicted by the Workers' Compensation Witness Report completed by Petitioner's direct supervisor. (PX7)

CONCLUSIONS

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

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

An injury is 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." *Laclede Steel. Co. v. Industrial Commission*, 128 N.E.2d 718, 720 (Ill. 1955); *General Electric Co. v. Industrial Commission*, 433 N.E.2d 671, 672 (Ill. 1982). In a repetitive trauma case, issues of accident and causation are intertwined. *Elizabeth Boettcher v. Spectrum Property Group and First Merit Venture*, 99 I.I.C. 0961 (1999). Accidental injury need not be the sole causative factor, nor even the primary causative factor, as long as it is a causative factor in the resulting condition of ill-being. *Sisbro, Inc. v. Indus. Comm'n*, 797 N.E.2d 665, 672-73 (Ill. 2003) (emphasis added). As in establishing accident, to show causal connection Petitioner need only show that some act or phase of the employment was a causative factor of the resulting injury. *Fierke v. Industrial Commission*, 723 N.E.2d 846 (3rd Dist. 2000).

In *Edward Hines Precision Components v. Indus. Comm'n*, 825 N.E.2d 773, (2nd Dist. 2005). the Court expressly stated, "There is no legal requirement that a certain percentage of the workday be spent on a task in order to support a finding of repetitive trauma." *Id.* at N.E.2d 780. Similarly, the Commission recently noted in *Dorhesca Randell v. St. Alexius Medical Center*, 13 I.W.C.C. 0135 (2013), a repetitive trauma claim, a claimant must show that work activities are a cause of his or her condition; the claimant does not have to establish that the work activities are the sole or primary cause, and there is no requirement that a claimant must spend a certain amount of time each day on a specific task before a finding of repetitive trauma can be made. *Randell* citing *All Steel, Inc. v. Indus. Comm'n*, 582 N.E.2d 240 (2nd Dist. 1991) and *Edward Hines supra.*

The Appellate Court in *City of Springfield v. Illinois Workers' Comp. Comm'n*, 901 N.E.2d 1066 (4th Dist., 2009) issued a favorable decision in a repetitive trauma case to a claimant whose work was "varied" but also "repetitive" or "intensive" in that he used his hands, albeit for different task, for at least five (5) hours out of an eight (8) hour work day. *Id.* "While [claimant's] duties may not have been 'repetitive' in a sense that the same thing was done over and over again as on an assembly line, the Commission finds that his duties required an intensive use of his hands and arms and his injuries were certainly cumulative." *Id.*

In this case, the evidence shows that Petitioner used his hands and arms extensively during the performance of his job duties for Respondent. Further, the Arbitrator finds the opinions and testimony of Dr. Young much more persuasive than those of Dr. Sudekum in this case.

Based upon the foregoing and the record taken as a whole, the Arbitrator finds Petitioner met his burden of establishing that he did sustain an accident which arose out of and in the course of his employment by the Respondent and that his current condition of ill-being is related to the injury.

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

The Workers' Compensation Act is a humane law of a remedial nature that should be liberally construed to achieve its purpose. *Hagene v. Derek Polling Const.*, 388 Ill. App. 3d 380, 902 N.E.2d 1269 (2009). Hence, the Supreme Court has established a flexible but fair standard for determining manifestation dates in repetitive trauma claims. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007). Although the date on which the employee becomes aware that he has a condition related to work was the first method for determining a manifestation date, it is not the only permissible means for alleging or proving manifestation. The manifestation date can be set as: (a) the date the employee actually became aware of the physical condition and its relation to work through medical consultation; (b) the date the employee requires medical treatment; (c) the date on which the employee can no longer perform work activities; or (d) when a reasonable person would have plainly recognized the injury and its relation to work. *Durand v. Industrial Commission*, 224 Ill.2d 53, 862 N.E.2d 918 (Ill. 2007), *see also Peoria County Belwood Nursing Home v. Industrial Commission*, 115 Ill.2d 524, 505 N.E.2d 1026 (Ill. 1987); *Oscar Mayer & Co. v. Industrial Commission*, 176 Ill.App.3d 607, 531 N.E.2d 174 (3rd Dist. 1988); *Three "D" Discount Store v. Industrial Commission*, 198 Ill.App.3d 43, 556 N.E.2d 261 (4th Dist. 1989).

Although a claimant is aware of symptoms and carries a suspicion that these are work-related, the Supreme Court has stated, "The 'fact of injury' is not synonymous with the 'fact of discovery'" *Durand,* N.E.2d at 927. Claimants are not charged with filing a claim as soon as they believe they may have a work-related condition, nor are they penalized for failing to realize a condition is work-related when the employer feels that he or she should have. The Supreme Court stated that to rely solely on a claimant's testimony concerning symptoms, without accurate knowledge of the cause of those symptoms, would essentially be asking them to "rely on 'expert' medical testimony from a layperson." *Id.* at 929. The Court also recognized that claimants would have had difficulty proving injury with a sketchy and equivocal understanding of the cause of their symptoms. *Id.* at 930. The standard that "the 'fact of injury' is not synonymous with the 'fact of discovery'" has since become a safety measure employed by all Courts to ensure that the employers do "penalize an employee who diligently worked through" his or her symptoms. *Durand v. Indus. Comm'n*, 862 N.E.2d at 927, 930. In *Durand*, the claimant was not sure her pain was from carpal tunnel syndrome, but "she believed it was work-related" in 1997, some 3 years before her injuries manifested in 2000. *Durand v. Indus. Comm'n*, 862 N.E.2d at 929-30.

In *Oscar Mayer*, the Court embraced the "date of collapse" method of determination, setting the manifestation date on the date of surgery, or the date the employee could no longer work. Compensation was awarded to a claimant, despite his full knowledge that his condition was work-related well before he filed a claim, because the claimant diligently served his employer until he could no longer do so without intervention for his repetitive injuries. *Oscar Mayer supra.* The Court noted that no prejudice can occur in employing such a method, since it is not until the employee actually misses work for his injuries that the employer becomes adversely affected; and the notice provisions were not impugned as this flexible and fair provision in no way interfered with an employer's ability to effectively investigate the claim.

In *Three "D" Discount*, the Court held the manifestation date of claimant's injury was the date "petitioner first learned that his condition of ill-being was work related." (*Id.*, 556 N.E.2d at 265) The Court went on to caution "[a]lthough our finding that the injury in this case 'manifested itself' on July 10, rather than August 10, does not affect the Commission's ruling in petitioner's favor, we emphasize that the peculiar facts of each case must be closely analyzed in repetitive-trauma cases to be fair to the faithful employee and his employer as well as to the employer's compensation insurance carrier." (*Id.*)

The Supreme Court in *Durand* noted that the manifestation date is typically set on the date the employee requires medical treatment or the date on which the employee can no longer perform work activities. *Durand,* 862 N.E.2d at 929. The law also allows Petitioner to select a manifestation date that coincides with discovery of injury and its relation to work after medical consultation. See *Steven Beal v. Town of Normal,* 06 IL.W.C. 25261, 10 I.W.C.C. 0380 (2010); *see also White v Worker's Compensation Commissio*n, 374 Ill.App.3d 907, 873 N.E.2d 388, 392-393 (4th Dist. 2007) (holding Petitioner could select accident date); *A.C. & S. v. Industrial Commission*, 304 Ill.App.3d 875, 710 N.E.2d 837, 841-842 (1st Dist. 1999).

In *Linda Peters v. Village of Caseyville*, the Commission gave the most weight to when the claimant possessed a "confirmed diagnosis" of her condition in setting the manifestation date. *Linda Peters v. Village of Caseyville*, 14 I.W.C.C. 0796 (2014). The Commission stated:

> The Commission finds that the manifestation date of Petitioner's right carpal tunnel syndrome was March 1, 2012. Although the parties had stipulated to an accident date of September 1, 2010, we find that it is within our discretion to change the accident date to conform-to the evidence. *See Beal v. Town of Normal*, 10 IWCC 380 (2010). The medical records are clear that the first mention of any correlation between Petitioner's right carpal tunnel syndrome and her work duties is the March 1, 2012, office note of Dr. Mirly. Although Petitioner's report of injury on March 2, 2012, indicates a date of accident of "Sept 2011," we find that this is not an appropriate manifestation date in this case because Petitioner did not have a confirmed diagnosis at that time. Based on our determination of the date of accident, we find that Petitioner provided timely notice of her accidental injuries. *Id.*

In this case Petitioner's condition was first definitively diagnosed on April 2, 2014 when Dr. Sawar performed a nerve conduction study and an EMG which revealed moderately severe right median mononeuropathy at the wrist (i.e. carpal tunnel syndrome) without active denervation and mild left median mononeuropathy at the wrist without denervation; and referred Petitioner to Dr. Young. The Arbitrator finds that April 2, 2014 is an appropriate manifestation date under the Act.

Petitioner testified that he filled out a Notice of Injury in September 2014, but had told his foreman, David Bryant, about the problem with his hands prior to that time. This testimony is confirmed by Mr. Bryant's witness statement on which he indicates he was aware of Petitioner's symptoms and their relationship to the employment on April 2, 2014. (PX7)

Based upon the foregoing and the record taken as a whole, the Arbitrator finds that Petitioner has provided proper notice as required by the Act.

Issue (J): Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?

Respondent did not dispute the reasonableness and necessity of the medical expenses Petitioner incurred. Respondent's dispute was on the basis of accident, notice and medical causation. Petitioner submitted the following medical bills:

Dr. Steven Young	$ 4,278.00
SIOC Surgery Center	$ 5,150.00
Brigham Anesthesia	$ 570.00
NovaCare	$ 346.00
Dr. Amar Sawar	$ 2,090.50
	$12,434.50

Based upon the foregoing and the record taken as a whole, including the finds with respect to issues (c) (e) and (f) above, Respondent shall pay reasonable and necessary medical services of $12,434.5, 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.

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

The parties stipulated that Petitioner was temporarily totally disabled between October 3, 2014 and November 20, 2014, representing seven (7) weeks. Respondent denied its obligation to pay these benefits on the basis of accident, notice and medical causation. Based upon the foregoing and the record taken as a whole, including the finds with respect to issues (c) (e) and (f) above, Respondent shall pay Petitioner temporary total disability benefits of $864.27/week for 7 weeks, commencing 10/3/14 through 11/20/14, as provided in Section 8(b) of the Act.

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

Pursuant to §8.1b of the Act, permanent partial disability from injuries that occur after September 1, 2011 is to be established using the following criteria: (i) the reported level of impairment pursuant to subsection (a) of §8.1b 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).

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that neither party submitted an impairment rating. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes Petitioner continues to work as a locksmith using his upper extremities. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 59 years old at the time of his injury. Petitioner has diminished healing capacity and a low threshold for future injury as a result

thereof. Furthermore, Petitioner has hand and arm intensive employment as a locksmith. The Arbitrator therefore gives *some* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes there is no direct evidence of reduced earning capacity contained in the record. The Arbitrator therefore gives *no* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes the Petitioner was a credible witness. Dr. Young diagnosed bilateral carpal tunnel syndrome which resulted in an invasive operative procedure to correct a severe thickening of the transverse carpal ligament in Petitioner's right hand. Petitioner made a good recovery and continues to work for Respondent as a locksmith. The Arbitrator therefore gives *some* weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 10% loss of use of the right hand pursuant to §8(e) of the Act. Respondent shall pay Petitioner the sum of $721.66/week for 19 weeks, as provided in Section 8(e) of the Act, because the injuries sustained caused 10% loss of the right hand.

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

Debra James,
Petitioner,

vs.

NO: 10 WC 13841

Illinois Department of Human Services,
Respondent.

17IWCC0514

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 what is the nature and extent of Petitioner's permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 2016 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 required for State of Illinois cases.

DATED: AUG 18 2017

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mas
o:8/1/17
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JAMES, DEBRA
Employee/Petitioner

Case# **10WC013841**

09WC015218

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0514

On 11/29/2016, 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 0.61% 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
JULL WAGNER
10 N DEARBORN ST SUITE 500
CHICAGO, IL 60654

5705 ASSISTANT ATTORNEY GENERAL
CAITLIN PAPADOPOULOS
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

1745 DEPT OF HUMAN SERVICES
BUREAU OF RISK MANAGEMENT
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

NOV 29 2016

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

17IWCC0514

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

Debra James
Employee/Petitioner

v.

Illinois Dept. of Human Services
Employer/Respondent

Case # **10** WC **13841**

Consolidated cases: **09 WC 15218**

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 **October 24, 2016** . 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 _____

17IWCC0514

FINDINGS

On **April 1, 2010** , Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain repetitive trauma injuries arising out of and in the course of employment.

Timely notice of these injuries *was* given to Respondent.

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

In the year preceding the injury, Petitioner earned $65,000; the average weekly wage was $ **1,163.46** .

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 $87,006.55 for TTD (total paid in both cases), $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $87,006.55. PETITIONER DID NOT PLACE TTD AT ISSUE. THE DATES OF TTD PAYMENTS ARE REFLECTED IN RX 6.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the fee schedule, of $ 3,724.83 to Illinois Physicians Network as provided in Sections 8(a) and 8.2 of the Act and with Respondent receiving credit for the payments, if any, it made toward said bill, as reflected in RX 6.

Respondent shall pay Petitioner permanent partial disability benefits of $664.72/week for 56.375 weeks, because the injuries sustained resulted in permanency equivalent to 12.5% loss of use of the right hand (25.625 weeks) and 15% loss of use of the left hand (30.75 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.

Molly C Mason

Signature of Arbitrator

11/29/16
Date

NOV 29 2016

Debra James v. Illinois Department of Human Services
09 WC 15218 and 10 WC 13841 (consolidated)

Summary of Disputed Issues

Petitioner alleges repetitive trauma in both of her claims. In 09 WC 15218, she seeks benefits for a right ring trigger finger condition manifesting on March 27, 2009. In 10 WC 13841, she alleges bilateral carpal tunnel syndrome manifesting on April 1, 2010. Arb Exh 1.

The following issues are in dispute in each case: accident, causal connection, $8,594.65 (total) in outstanding medical expenses and permanency. The parties agree that Respondent paid $87,006.55 in temporary total disability benefits and $55,257.85 in medical expenses prior to trial. The Request for Hearing form (Arb Exh 1) does not reflect how much of these stipulated totals were paid in each case but Respondent offered payment print-outs into evidence. RX 6.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified she worked for Respondent for 29 years before retiring in 2015. She started out as a secretary. After four years, she became a caseworker, assisting individuals who were applying to renew food stamp benefits. Her caseworker duties involved interviewing clients, while inputting data on a computer, and responding to inquiries via telephone. She testified she "moved around a lot" within the same office but typically worked at a standard desk, with a computer in front of her and a telephone either in front of or behind her. She had no headset.

Petitioner testified she typically interviewed 10 to 15 clients per day, pursuant to a pre-set schedule, but was also required to interview clients who lacked appointments and simply walked in. In connection with each interview, she had to go to a file room in order to retrieve the client's file. She described the file room as "messed up." The files were supposed to be in file cabinet drawers, in alphabetical order, but were frequently left on the floor or stacked haphazardly on top of the cabinets. Once she retrieved a client's file, she returned to her desk and began the interview, entering information on the computer as she went along. She used a mouse, which she held with her dominant right hand, while inputting data. If her telephone rang during an interview, she had to put the interview on hold and respond to the caller's inquiries. When she worked at a desk with the phone positioned behind her, she had to reach back in order to answer a call. If the caller had a claim-related question, she would have to retrieve the relevant file and/or check the computer in order to respond.

Petitioner testified her normal work week consisted of 40 hours, Monday through Friday. On direct examination, she estimated she was on her computer 75% of each workday.

Petitioner testified she began experiencing pain in her right ring finger before March 27, 2009. On that date, her right ring finger "locked." She notified her supervisor, Miss Pittman, of

this. [Notice is not in dispute.] She saw Dr. Tansey at Bone and Joint Physicians the same day. In his note, the doctor indicated that Petitioner had been experiencing pain over the base of her right ring finger for about one month. He described the pain as "associated with triggering." On examination, he noted a full range of hand motion and triggering of the right ring finger. After discussing various treatment options with Petitioner, he administered a steroid injection. He directed Petitioner to "avoid exacerbating activities" and return in three weeks. PX 2.

Petitioner testified the injection did not relieve her symptoms. She did not return to work as Respondent was not able to accommodate the doctor's restriction.

On April 2, 2009, Petitioner returned to Dr. Tansey and reported persistent symptoms. The doctor noted no hand swelling and triggering of the right long finger [the reference to the long finger appears to be an error.] He took Petitioner off work for one week and recommended a right hand MRI. On April 8, 2009, he issued a note indicating Petitioner should remain off work until April 13, 2009. PX 2.

Petitioner underwent the recommended MRI on April 10, 2009. The radiologist interpreted the study as showing minimal fluid at the level of the proximal phalanges of the four and fifth digits of the right hand. The radiologist indicated the median nerve looked normal. PX 2.

Petitioner returned to Dr. Tansey on May 12, 2009 and again complained of triggering in her right ring finger. On re-examination, the doctor noted no hand swelling and triggering in the affected finger. He reviewed the MRI results with Petitioner. He directed Petitioner to continue to avoid exacerbating activities and return to him in four weeks for consideration of another injection or possibly surgery. PX 2.

Petitioner saw Dr. Tansey again on June 9, 2009. The doctor noted she was still experiencing some pain and occasional triggering in her right ring finger. A workers' compensation form dated June 9, 2009 reflects that Petitioner "writes and types 95% of day" and attributed her injury to "too much typing with[out] the right equipment."

On re-examination, Dr. Tansey noted minimal hand swelling, a decreased range of motion of the right ring finger MCP joint and minimal triggering. He discussed the possibility of surgery and indicated Petitioner wanted to "hold off on that." He took Petitioner off work and directed her to continue to avoid exacerbating activities. PX 2.

Petitioner returned to Dr. Tansey on July 7, 2009 and complained of increasing pain in her right ring finger. The doctor noted triggering of the affected finger on re-examination. He discussed the risks of trigger release surgery with Petitioner and indicated Petitioner wanted to proceed. He stated he would require "work comp approval" in order to schedule the procedure. PX 2.

A "WC procedure authorization request form" in Dr. Tansey's records reflects that Bob Dunlap, an adjuster, provided written authorization for the contemplated trigger release. The form sets forth a date of injury of March 9, 2009. PX 2.

Dr. Wiesman, a plastic and reconstructive surgeon, performed a right ring finger A1 pulley release on August 12, 2009. In his operative report of that date, the doctor noted "some thickening along the tendon sheath." PX 3.

On August 17, 2009, Dr. Wiesman noted normal wound healing and directed Petitioner to stay off work and begin occupational therapy. PX 3.

Petitioner began a course of therapy at AthletiCo thereafter. A "phone screening form" in the AthletiCo records reflects that Petitioner reported being injured on the job on March 9, 2009. An initial therapy evaluation note of August 18, 2009 reflects that Petitioner attributed her injury and surgery to performing repetitive typing, writing and phone holding as a caseworker for Respondent. PX 5.

On August 31, 2009, Dr. Wiesman removed Petitioner's sutures and directed Petitioner to continue therapy. He completed a form indicating Petitioner could resume one-handed duty on September 8, 2009. PX 3.

On September 15, 2009, Petitioner's therapist noted a complaint of persistent pain in the right volar ring finger. PX 5.

An AthletiCo therapy progress note dated September 24, 2009 reflects that "skin thickness at the surgical site remain[ed] a significant deficit" and that Petitioner "continues with difficulty with work activities such as typing, grasping for extended periods of time due to pain at surgical site." The therapist indicated that Petitioner "has not returned to work as a case manager with job functions [of] typing and writing repetitively." She recommended three more weeks of therapy. PX 3, 5.

On September 28, 2009, Dr. Wiesman noted "slight thickening of the scar" and directed Petitioner to return in eight weeks. He imposed no restrictions. PX 3.

Petitioner testified she remained off work and continued attending therapy.

On October 5, 2009, Petitioner saw Dr. Gelman. In a lengthy note of that date, the doctor indicated Petitioner had come to see him because she remained symptomatic and was unhappy with Dr. Wiesman and her surgical results. He noted that Dr. Wiesman had placed his incision obliquely from the MP flexion crease and across the palm overlying the Al pulley. He described this as different from the incision he typically used, which was proximal to the A1 pulley in the palm. He noted a "significantly fibrotic scar on the distal aspect of the incision at the flexion crease and obvious swelling of the finger." He diagnosed a "suture abscess." He drained purulence from the wound and indicated Petitioner might require scar revision. He

directed Petitioner to continue occupational therapy at AthletiCo. He imposed restrictions of limited grasping, squeezing and carrying with the right hand. He directed Petitioner to return to him in two weeks. PX 4.

Petitioner returned to Dr. Gelman on October 15, 2009 and reported improvement. The doctor noted persistent tenderness and mild swelling but described the swelling as improved since the initial visit. He noted that Petitioner's therapist had resigned. He recommended a new therapist at Accelerated Rehabilitation and continued the previous work restrictions. PX 4.

At the next visit, on October 29, 2009, Dr. Gelman noted that the abscess had resolved but that Petitioner was now developing recurrent triggering. He stated it was unclear whether the A1 pulley was completely released at the first surgery. He recommended additional therapy along with a "re-do" pulley release. He continued the previous work restrictions. PX 4.

On November 12, 2009, Dr. Gelman noted "obvious continued triggering" and again recommended a "re-do" surgery. He continued the previous work restrictions. PX 4.

Forms in Dr. Gelman's records reflect that Respondent pre-authorized the "re-do" surgery. Dr. Gelman performed this surgery on December 10, 2009. In his operative report, he described the A2 pulley as "partially destroyed." At the first post-operative visit, on December 15, 2009, he described Petitioner as "doing very well." PX 4.

On December 31, 2009, Dr. Gelman prescribed "aggressive occupational therapy" and upgraded the restrictions to limited grasping, squeezing and carrying with the right hand. PX 4.

On January 28, 2010, Dr. Gelman recommended three more weeks of therapy, followed by a home program. He continued the previous restrictions. PX 4.

On February 18, 2010, Dr. Gelman released Petitioner to full duty as of March 1, 2010. He found Petitioner to be at maximum medical improvement but recommended she continue a home exercise program. PX 4.

Petitioner testified she resumed her regular caseworker duties on March 1, 2010. A month later, she began experiencing pain shooting through both of her arms. She reported her symptoms to her supervisor, Ms. Pittman. On April 5, 2010, she signed a Form 45 indicating she injured her left ring and right middle fingers and developed bilateral carpal tunnel syndrome on March 24, 2010 due to "repetitive use of keyboard and writing." RX 3.

Petitioner returned to Dr. Gelman on April 15, 2010. In his note of that date, the doctor indicated Petitioner presented "with new complaints distinct from" her prior right ring finger problem. He indicated that Petitioner complained of paresthesias in the median nerve distribution of both hands, right more than left, nocturnal paresthesias every night and dropping objects. On examination, he noted a markedly positive Tinel's over the median nerve at the carpal tunnel bilaterally, a positive Phalen's test bilaterally, triggering of the left ring

finger and triggering of the right middle finger. He described the triggering as "severe, with locking." In light of these symptoms, and the prior surgery, he recommended that Petitioner undergo surgery rather than an initial course of conservative care. He suggested that Petitioner initially undergo a left ring finger trigger finger release and left carpal tunnel release and later undergo a right middle finger trigger finger release and right carpal tunnel release. He also indicated he completed an initial workers' compensation report and work status report. On these forms, he described the "history (description of accident) as "N/A" and restricted Petitioner to limited grasping, squeezing and carrying. PX 4.

At the next visit, on May 27, 2010, Dr. Gelman noted that Petitioner reported "some increased symptomatology with keyboarding." [Petitioner did not testify to having resumed working at this point. She testified Respondent was not able to accommodate the doctor's restrictions.] He also noted he was still awaiting authorization of the proposed surgeries. He added a work restriction of limited keyboarding. PX 4.

A work status report in Dr. Gelman's records reflects that Bob Dunlap of Respondent's CMS risk management division approved the proposed surgeries on June 21, 2010. PX 4.

On June 28, 2010, Dr. Gelman described Petitioner as "ready to proceed with surgery on the left hand." He indicated he made Petitioner aware "that the left hand may not do as well as the right." PX 4.

Records and bills in PX 4 reflect that Dr. Gelman performed a left carpal tunnel release and a left ring finger trigger release at Munster Same Day Surgery Center on July 8, 2010. The operative report is not in evidence. On July 19, 2010, Dr. Gelman released Petitioner to strictly right-handed work, indicating she should remain off if this kind of work was not available. He directed Petitioner to continue attending therapy.

On August 12, 2010, Dr. Gelman noted that Petitioner had made "marked progress in therapy" and exhibited no triggering or signs of carpal tunnel. He continued the right-handed work restriction. On September 3, 2010, the doctor directed Petitioner to continue therapy for three more weeks. On September 16, 2010, he noted more progress and continued the right-handed work restriction. On October 7, 2010, he released Petitioner to light duty with limited grasping, squeezing, carrying and keyboard usage. He indicated he planned to schedule the right-sided procedures. PX 4.

There is no evidence indicating Petitioner returned to Dr. Gelman after October 7, 2010.

Petitioner testified that a different physician, Dr. Rubinstein (of the Illinois Bone and Joint Institute), performed a right carpal tunnel release on January 27, 2011. No operative report of that date is in evidence. The doctor's bill (PX 1), however, shows an initial office visit of November 1, 2010 and a neuroplasty surgery on January 27, 2011. Therapy records in PX 4 show that Dr. Rubinstein performed a right middle finger trigger release on May 12, 2011.

The Illinois Bone & Joint records document an office visit of June 29, 2011, with the doctor noting some residual flexion contracture at the PIP joint and recommending ongoing therapy. On September 26, 2011, Dr. Rubinstein noted that Petitioner's flexion contracture was "working out" and that, with active and passive motion, he could almost get the finger corrected to zero. He released Petitioner to light duty, with no keyboarding, "as this would disrupt the balancing of her ligaments." On August 1, 2011, Dr. Rubinstein noted that Petitioner's progress had been delayed due to lack of approval for recommended hand therapy. He indicated Petitioner's finger was no longer triggering but that she still had a flexion contracture. He released Petitioner to restricted work using only the non-operated hand. On August 31, 2011, Dr. Rubinstein noted that Petitioner still had a flexion contracture of 5 to 10 degrees when fatigued. He released Petitioner to light duty with no typing or computer usage. On October 26, 2011, Dr. Rubinstein indicated that Petitioner was making progress in therapy. He noted full flexion and near full extension of "the finger," presumably referring to the right middle finger, but "a little bit of deficit with extension against resistance." He recommended that Petitioner continue therapy. He imposed restrictions of no grasping and no keyboard use. PX 6.

Records from Maximum Rehabilitation show that, as of December 1, 2011, Petitioner's right middle finger range of motion and right hand grip strength had improved. Petitioner was discharged from therapy on December 8, 2011 "due to other medical issues." PX 6.

Petitioner testified that, at some point, Dr. Rubenstein recommended an ergonomic keyboard but that Respondent never provided this equipment.

Petitioner testified she last underwent care for her injuries on January 3, 2012. [No treatment note of that date is in evidence.] She resumed her regular job duties thereafter and retired in 2015.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Fernandez on August 26, 2014. Dr. Fernandez is a board certified orthopedic surgeon affiliated with Rush University Medical Center. RX 4 at 5.

Dr. Fernandez indicated he received and reviewed only a few medical records, including the right carpal tunnel release operative report, in connection with the examination. He also indicated he did not receive any job description.

Dr. Fernandez indicated that Petitioner provided a history of hand and finger symptoms dating back to 2004 which she associated with computer usage at her job. He stated that Petitioner described herself as "doing much better" following surgery and complained only of minor weakness primarily affecting her left hand and pain in cold weather. He noted that Petitioner had been off work since October 2013 due to a knee injury.

On examination, Dr. Fernandez noted "multiple well-healed surgical scars involving the right hand," some mild paresthesias in the left hand median nerve distribution, negative Tinel's,

Phalen's and median nerve compression testing bilaterally, generalized weakness in both hands, right greater than left, mild tenderness along the A1 pulleys diffusely in both hands, no active triggering or locking and a full range of motion actively and passively.

Dr. Fernandez obtained multiple X-rays of both hands and wrists. He interpreted the films as showing normal bone quality and alignment, with no evidence of fracture, dislocation or degenerative process.

Dr. Fernandez assessed Petitioner as having had a good response to the right carpal tunnel release and "some residual numbness and tingling on the left side consistent with possible carpal tunnel syndrome." [It appears the doctor was unaware Petitioner had already undergone a left-sided release.] He opined that the carpal tunnel and triggering would not be considered work-related "unless [Petitioner] was exposed to significant and/or forceful gripping or grasping or frequent extension and flexion through the wrist." He went on to state that "the simple tasks or activities of keyboarding and/or data entry not be considered causative or aggravating." He indicated his opinions could change if he learned that Petitioner performed forceful gripping and grasping "in more than one third or one half of the work day or work cycle with flexion and extension through the wrist, although very frequent in nature." He recommended observation of Petitioner's right hand and indicated Petitioner might require a left carpal tunnel release [again, it appears he was unaware she had already undergone this release.] He found Petitioner to be at maximum medical improvement and capable of full duty. RX 4.

On December 17, 2014, Dr. Gelman sent a report to Petitioner's counsel. In this report, he responded to various causation-related inquiries. He opined that Petitioner's right ring trigger finger condition stemmed from her caseworker duties since these duties involved bending the fingers. He stated that bending the fingers "can result in trigger finger." He characterized the triggering-related care as reasonable and necessary, as well as causally related to Petitioner's job. He also found causation as to Petitioner's bilateral carpal tunnel syndrome, stating that "repeated keyboarding and writing can result" in this syndrome. He characterized the carpal tunnel release surgeries as reasonable and necessary, as well as related to Petitioner's job. PX 7.

At some later point, apparently on December 30, 2015 (RX 6, p. 6), Dr. Fernandez issued an undated "IME Addendum," after reviewing a Form 45 dated April 19, 2010, a caseworker job description and Dr. Gelman's notes. He indicated that, according to the job description, Petitioner was required to lift 1 to 10 pounds less than three times per week, was never required to lift more than 10 pounds and used her hands for gross and/or fine manipulation approximately 2 to 4 hours per day. [The job description is not in evidence.]

Dr. Fernandez indicated that he considered the term "forceful gripping" to mean "gripping, grasping, pushing or pulling in excess of 20 to 40 pounds, particularly on a more frequent" basis. He stated the term did not refer to writing, typing or phone usage. He

indicated that, in general, the term was intended to refer to work that would cause calluses. He went on to state:

> "The only part that could be considered a possibility with regards to a data entry position will be if the individual was engaged in lifting and/or manipulating boxes of papers which could weigh in excess of 20 pounds two to three hours on a daily basis. This would be similar to archiving materials in a warehouse. There is no history of that here."

He further stated that flexion and extension of the wrists would have to be performed two to three hours per day to be considered frequent. He clarified that flexion and extension would typically be associated with use or a tool or machine and that "there would be no flexion/extension during keyboarding activities or writing." RX 5.

Petitioner testified she has never smoked and has never been diagnosed with diabetes or heart disease. Respondent paid all of her temporary total disability benefits and most of her medical expenses.

Petitioner testified her injuries affect her daily life and typical activities. Her left hand is weaker than her right. It is difficult for her to lift bags of groceries, wring out dish towels and brush her teeth and hair.

Under cross-examination, Petitioner testified that, as of March 2009, she spent about seven hours per workday in front of a computer. She spent about 75% of her time keyboarding and 60% of her time using a mouse. She wrote by hand occasionally, perhaps 15% of the time. She resorted to writing by hand when the computers went down or she had to complete an application for a client who was unable to do this on his own. Completing an application required filling in blanks, not writing out paragraphs. Before she submitted an application, via computer, she had to state her opinion as to why or why not benefits should be renewed. She sat in a regular office chair. The chair did not have arm rests. Her desk was about as tall as the counsel desks in the hearing room. Her work duties in 2009 were different than those she previously performed because she (and others) worked overtime, on certain Saturdays, to clean up the file room. Respondent offered this overtime twice monthly and she accepted the offer. She could not recall how often she performed this overtime. In 2010, there was no change in her work station, hours or duties. She was released to full duty as of March 1, 2010 and resumed full duty at that time. She was again released to full duty on January 3, 2012 and resumed full duty at that time.

On redirect, Petitioner described a Respondent case file as larger than a Commission case file. Each file contained information and documents, such as a birth certificate, pertaining to a particular client. The bulk of each file varied, depending on its contents. Respondent's file room contained thousands of files. Some of the files were in cabinets, where they were

supposed to be. Others were on the floor or stacked on top of the cabinets. When she and others worked overtime, their goal was to put all of the files into cabinets. A cabinet could be as tall as 6 feet, if you included the files that were typically stacked on top of it.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in her favor, credibility-wise. Petitioner's description of her duties and the condition of the file room was detailed and unrebutted.

Overall, the Arbitrator found Petitioner very credible.

Arbitrator's Conclusions of Law Relative to Both Claims

Did Petitioner establish repetitive trauma injuries manifesting on March 27, 2009 and April 1, 2010? Did Petitioner establish a causal connection between said injuries and her current claimed right ring finger and bilateral hand/wrist conditions of ill-being?

In **09 WC 15218,** the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on March 27, 2009. The Arbitrator views March 27, 2009 as an appropriate manifestation date based on Petitioner's testimony as to the locking she experienced and the notice she provided on that date. The Arbitrator further finds that Petitioner established a causal connection between her repetitive trauma injuries and her current post-operative right ring finger condition of ill-being. In so finding, the Arbitrator relies on Petitioner's credible description of her duties, her credible account of the events of March 27, 2009, her credible denial of possible contributing systemic disorders such as diabetes, the records of Drs. Tansey, Wiesman and Gelman and Dr. Gelman's report. Dr. Gelman opined that triggering can be caused by bending the fingers. Petitioner would have had to repeatedly bend her fingers in order to keyboard, hold a phone or writing implement, move a computer mouse or extract a file from a stack. The Arbitrator notes that Respondent's examiner, Dr. Fernandez, did not question the trigger finger diagnosis and acknowledged he received only a few treatment records. Dr. Fernandez based his causation-related opinions on the assumption that Petitioner's job duties were limited to keyboarding, using a phone and "simple administrative tasks." He conceded that forceful gripping could contribute to the development of trigger finger and carpal tunnel syndrome but saw no evidence that Petitioner performed such gripping. At no time did he express any awareness of the condition of Respondent's file room or the fact that Petitioner was regularly required to pull files out of stacks and drawers in this room. Nor did he express any awareness of the duties Petitioner performed while helping clean the file room. He reviewed a job description, which is not in evidence, but there is no indication that this description accurately reflected Petitioner's duties insofar as file retrieval and lifting were concerned. Petitioner testified to having to retrieve and carry at least 10 to 15 client files per workday. She also testified to handling and rearranging files approximately sixteen hours per month while working overtime in 2009. No one rebutted her testimony that she was required to extract files from stacks and drawers.

In **10 WC 13841**, the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on April 1, 2010. The Arbitrator further finds that Petitioner established a causal connection between those injuries and her current post-operative bilateral carpal tunnel syndrome condition of ill-being. In so finding, the Arbitrator relies on Petitioner's credible description of her duties, her credible denial of possible contributing systemic disorders such as diabetes, the records of Drs. Gelman and Rubenstein and Dr. Gelman's report. The Arbitrator declines to rely on the causation opinions voiced by Dr. Fernandez, applying the analysis set forth in the preceding paragraph. The Arbitrator recognizes that Petitioner was off work during part of 2009 and had been back to work for only a month before she reported carpal tunnel symptoms. The Arbitrator finds it likely that these symptoms actually began before April 2010 but were overshadowed by the significant right ring finger problem.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causal connection.

Petitioner seeks an award of three medical bills totaling $8,594.65. PX 1. The Arbitrator recognizes that the payment of benefits is not an admission of liability but finds it ironic that the claimed bills relate to surgeries Respondent pre-authorized. Two of the bills relate to the August 12, 2009 surgery and the third relates to post-operative therapy rendered in 2011. The Arbitrator also notes that at no time did Respondent's examiner, Dr. Fernandez, question the necessity or reasonableness of Petitioner's care. RX 4-5.

In 09 WC 15218, the Arbitrator awards Petitioner Dr. Wiesman's bill in the amount of $3,189.82, subject to the fee schedule and with Respondent receiving credit for any payments it may have made toward this bill. [RX 6, a payment print-out, shows a payment for treatment rendered on August 12, 2009 but it is not clear whether this payment was made to Dr. Wiesman.] This bill relates to the trigger finger surgery of August 12, 2009 and several post-operative office visits through September 29, 2009. The Arbitrator also awards Petitioner the Windy City Anesthesia bill in the amount of $1,680.00, subject to the fee schedule. This bill relates to the anesthesia administered during the August 12, 2009 surgery. PX 1. Respondent's print-out (RX 6) does not reflect any payments to Windy City Anesthesia.

In 10 WC 13841, the Arbitrator awards Petitioner the Illinois Physicians Network bill of $3,724.83, subject to the fee schedule and with Respondent receiving credit for any payments it may have made toward this bill. [RX 6 shows various 2013 payments to Illinois Physicians Network for therapy rendered between August 2, 2011 and November 11, 2011.] This bill relates to therapy rendered in 2011.

What is the nature and extent of each injury?

Both claims are pre-amendatory since the injuries manifested prior to September 1, 2011.

In **09 WC 15218,** the Arbitrator awards permanency equivalent to 30% loss of use of the right ring finger, equivalent to 8.1 weeks of benefits. In making this award, the Arbitrator notes that the first surgery, performed by Dr. Wiesman, did not relieve Petitioner's symptoms and that, in his "re-do" operative report, Dr. Gelman described the A2 pulley as " partially destroyed." The Arbitrator also relies on Petitioner's credible testimony concerning her ongoing triggering.

In **10 WC 13841,** the Arbitrator awards permanency equivalent to 12.5% loss of use of the right hand (25.625 weeks) and 15% loss of use of the left hand (30.75 weeks), a total of 56.375 weeks. [The Arbitrator notes that, in 10 WC 13841, Petitioner did not seek permanency for any body parts other than her hands.] In making this award, the Arbitrator relies in part on the records of Drs. Gelman and Rubenstein. The Arbitrator awards a slightly higher percentage of loss for the left hand based on Petitioner's testimony and Dr. Fernandez's examination findings. Dr. Fernandez saw Petitioner after the left carpal tunnel release but did not know the release had been performed. He noted ongoing symptoms of left carpal tunnel syndrome and indicated Petitioner might need surgery. His findings support Petitioner's testimony as to ongoing left-sided symptoms.

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

Debra James,
Petitioner,

vs.

NO: 09 WC 15218

Illinois Department of Human Services,
Respondent.

17IWCC0515

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 what is the nature and extent of Petitioner's permanent disability and being advised of the facts and law, affirms and adopts the Decision of the Arbitrator, which is attached hereto and made a part hereof.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed November 29, 2016 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 required for State of Illinois cases.

DATED: AUG 18 2017

L. Elizabeth Coppoletti

LEC/mas
o:8/1/17
43

Charles J. DeVriendt

Joshua D. Luskin

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

JAMES, DEBRA
Employee/Petitioner

Case# **09WC015218**

10WC013841

ILLINOIS DEPT OF HUMAN SERVICES
Employer/Respondent

17IWCC0515

On 11/29/2016, 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 0.61% 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
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1745 DEPT OF HUMAN SERVICES
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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

NOV 29 2016

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

17IWCC0515

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

Debra James
Employee/Petitioner

v.

Illinois Dept. of Human Services
Employer/Respondent

Case # **09** WC **15218**

Consolidated cases: **10 WC 13841**

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 **October 24, 2016** . 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 _____

17IWCC0515

FINDINGS

On **March 27, 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 repetitive trauma injuries arising out of and in the course of employment.

Timely notice of these injuries ***was*** given to Respondent.

Petitioner's current right ring finger condition of ill-being ***is*** causally related to the repetitive trauma injuries.

In the year preceding the injury, Petitioner earned $65,000; the average weekly wage was $ **1,130.35** .

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

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

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

Respondent shall be given a credit of $87,006.55 for TTD (total paid in both cases), $ **0.00** for TPD, $ **0.00** for maintenance, and $ **0.00** for other benefits, for a total credit of $87,006.55. PETITIONER DID NOT PLACE TTD AT ISSUE. THE DATES OF THE TTD PAYMENTS ARE MEMORIALIZED IN RX 6.

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

ORDER

Respondent shall pay reasonable and necessary medical services, pursuant to the fee schedule, of $ 3,189.82 to Dr. Irvin Wiesman and $ 1,680.00 to Windy City Anesthesia , as provided in Sections 8(a) and 8.2 of the Act. With respect to Dr. Wiesman's bill, Respondent is entitled to credit for payments, if any, it made toward the claimant amounts, as reflected in RX 6.

Respondent shall pay Petitioner permanent partial disability benefits of $ 664.72 /week for 8.1 weeks, because the injuries sustained caused the 30 % loss of the right ring finger, 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.

Molly C Mason

Signature of Arbitrator

11/29/16

Date

NOV 29 2016

Debra James v. Illinois Department of Human Services
09 WC 15218 and 10 WC 13841 (consolidated)

Summary of Disputed Issues

Petitioner alleges repetitive trauma in both of her claims. In 09 WC 15218, she seeks benefits for a right ring trigger finger condition manifesting on March 27, 2009. In 10 WC 13841, she alleges bilateral carpal tunnel syndrome manifesting on April 1, 2010. Arb Exh 1.

The following issues are in dispute in each case: accident, causal connection, $8,594.65 (total) in outstanding medical expenses and permanency. The parties agree that Respondent paid $87,006.55 in temporary total disability benefits and $55,257.85 in medical expenses prior to trial. The Request for Hearing form (Arb Exh 1) does not reflect how much of these stipulated totals were paid in each case but Respondent offered payment print-outs into evidence. RX 6.

Arbitrator's Findings of Fact Relative to Both Cases

Petitioner testified she worked for Respondent for 29 years before retiring in 2015. She started out as a secretary. After four years, she became a caseworker, assisting individuals who were applying to renew food stamp benefits. Her caseworker duties involved interviewing clients, while inputting data on a computer, and responding to inquiries via telephone. She testified she "moved around a lot" within the same office but typically worked at a standard desk, with a computer in front of her and a telephone either in front of or behind her. She had no headset.

Petitioner testified she typically interviewed 10 to 15 clients per day, pursuant to a pre-set schedule, but was also required to interview clients who lacked appointments and simply walked in. In connection with each interview, she had to go to a file room in order to retrieve the client's file. She described the file room as "messed up." The files were supposed to be in file cabinet drawers, in alphabetical order, but were frequently left on the floor or stacked haphazardly on top of the cabinets. Once she retrieved a client's file, she returned to her desk and began the interview, entering information on the computer as she went along. She used a mouse, which she held with her dominant right hand, while inputting data. If her telephone rang during an interview, she had to put the interview on hold and respond to the caller's inquiries. When she worked at a desk with the phone positioned behind her, she had to reach back in order to answer a call. If the caller had a claim-related question, she would have to retrieve the relevant file and/or check the computer in order to respond.

Petitioner testified her normal work week consisted of 40 hours, Monday through Friday. On direct examination, she estimated she was on her computer 75% of each workday.

Petitioner testified she began experiencing pain in her right ring finger before March 27, 2009. On that date, her right ring finger "locked." She notified her supervisor, Miss Pittman, of

this. [Notice is not in dispute.] She saw Dr. Tansey at Bone and Joint Physicians the same day. In his note, the doctor indicated that Petitioner had been experiencing pain over the base of her right ring finger for about one month. He described the pain as "associated with triggering." On examination, he noted a full range of hand motion and triggering of the right ring finger. After discussing various treatment options with Petitioner, he administered a steroid injection. He directed Petitioner to "avoid exacerbating activities" and return in three weeks. PX 2.

Petitioner testified the injection did not relieve her symptoms. She did not return to work as Respondent was not able to accommodate the doctor's restriction.

On April 2, 2009, Petitioner returned to Dr. Tansey and reported persistent symptoms. The doctor noted no hand swelling and triggering of the right long finger [the reference to the long finger appears to be an error.] He took Petitioner off work for one week and recommended a right hand MRI. On April 8, 2009, he issued a note indicating Petitioner should remain off work until April 13, 2009. PX 2.

Petitioner underwent the recommended MRI on April 10, 2009. The radiologist interpreted the study as showing minimal fluid at the level of the proximal phalanges of the four and fifth digits of the right hand. The radiologist indicated the median nerve looked normal. PX 2.

Petitioner returned to Dr. Tansey on May 12, 2009 and again complained of triggering in her right ring finger. On re-examination, the doctor noted no hand swelling and triggering in the affected finger. He reviewed the MRI results with Petitioner. He directed Petitioner to continue to avoid exacerbating activities and return to him in four weeks for consideration of another injection or possibly surgery. PX 2.

Petitioner saw Dr. Tansey again on June 9, 2009. The doctor noted she was still experiencing some pain and occasional triggering in her right ring finger. A workers' compensation form dated June 9, 2009 reflects that Petitioner "writes and types 95% of day" and attributed her injury to "too much typing with[out] the right equipment."

On re-examination, Dr. Tansey noted minimal hand swelling, a decreased range of motion of the right ring finger MCP joint and minimal triggering. He discussed the possibility of surgery and indicated Petitioner wanted to "hold off on that." He took Petitioner off work and directed her to continue to avoid exacerbating activities. PX 2.

Petitioner returned to Dr. Tansey on July 7, 2009 and complained of increasing pain in her right ring finger. The doctor noted triggering of the affected finger on re-examination. He discussed the risks of trigger release surgery with Petitioner and indicated Petitioner wanted to proceed. He stated he would require "work comp approval" in order to schedule the procedure. PX 2.

A "WC procedure authorization request form" in Dr. Tansey's records reflects that Bob Dunlap, an adjuster, provided written authorization for the contemplated trigger release. The form sets forth a date of injury of March 9, 2009. PX 2.

Dr. Wiesman, a plastic and reconstructive surgeon, performed a right ring finger A1 pulley release on August 12, 2009. In his operative report of that date, the doctor noted "some thickening along the tendon sheath." PX 3.

On August 17, 2009, Dr. Wiesman noted normal wound healing and directed Petitioner to stay off work and begin occupational therapy. PX 3.

Petitioner began a course of therapy at AthletiCo thereafter. A "phone screening form" in the AthletiCo records reflects that Petitioner reported being injured on the job on March 9, 2009. An initial therapy evaluation note of August 18, 2009 reflects that Petitioner attributed her injury and surgery to performing repetitive typing, writing and phone holding as a caseworker for Respondent. PX 5.

On August 31, 2009, Dr. Wiesman removed Petitioner's sutures and directed Petitioner to continue therapy. He completed a form indicating Petitioner could resume one-handed duty on September 8, 2009. PX 3.

On September 15, 2009, Petitioner's therapist noted a complaint of persistent pain in the right volar ring finger. PX 5.

An AthletiCo therapy progress note dated September 24, 2009 reflects that "skin thickness at the surgical site remain[ed] a significant deficit" and that Petitioner "continues with difficulty with work activities such as typing, grasping for extended periods of time due to pain at surgical site." The therapist indicated that Petitioner "has not returned to work as a case manager with job functions [of] typing and writing repetitively." She recommended three more weeks of therapy. PX 3, 5.

On September 28, 2009, Dr. Wiesman noted "slight thickening of the scar" and directed Petitioner to return in eight weeks. He imposed no restrictions. PX 3.

Petitioner testified she remained off work and continued attending therapy.

On October 5, 2009, Petitioner saw Dr. Gelman. In a lengthy note of that date, the doctor indicated Petitioner had come to see him because she remained symptomatic and was unhappy with Dr. Wiesman and her surgical results. He noted that Dr. Wiesman had placed his incision obliquely from the MP flexion crease and across the palm overlying the Al pulley. He described this as different from the incision he typically used, which was proximal to the A1 pulley in the palm. He noted a "significantly fibrotic scar on the distal aspect of the incision at the flexion crease and obvious swelling of the finger." He diagnosed a "suture abscess." He drained purulence from the wound and indicated Petitioner might require scar revision. He

directed Petitioner to continue occupational therapy at AthletiCo. He imposed restrictions of limited grasping, squeezing and carrying with the right hand. He directed Petitioner to return to him in two weeks. PX 4.

Petitioner returned to Dr. Gelman on October 15, 2009 and reported improvement. The doctor noted persistent tenderness and mild swelling but described the swelling as improved since the initial visit. He noted that Petitioner's therapist had resigned. He recommended a new therapist at Accelerated Rehabilitation and continued the previous work restrictions. PX 4.

At the next visit, on October 29, 2009, Dr. Gelman noted that the abscess had resolved but that Petitioner was now developing recurrent triggering. He stated it was unclear whether the A1 pulley was completely released at the first surgery. He recommended additional therapy along with a "re-do" pulley release. He continued the previous work restrictions. PX 4.

On November 12, 2009, Dr. Gelman noted "obvious continued triggering" and again recommended a "re-do" surgery. He continued the previous work restrictions. PX 4.

Forms in Dr. Gelman's records reflect that Respondent pre-authorized the "re-do" surgery. Dr. Gelman performed this surgery on December 10, 2009. In his operative report, he described the A2 pulley as "partially destroyed." At the first post-operative visit, on December 15, 2009, he described Petitioner as "doing very well." PX 4.

On December 31, 2009, Dr. Gelman prescribed "aggressive occupational therapy" and upgraded the restrictions to limited grasping, squeezing and carrying with the right hand. PX 4.

On January 28, 2010, Dr. Gelman recommended three more weeks of therapy, followed by a home program. He continued the previous restrictions. PX 4.

On February 18, 2010, Dr. Gelman released Petitioner to full duty as of March 1, 2010. He found Petitioner to be at maximum medical improvement but recommended she continue a home exercise program. PX 4.

Petitioner testified she resumed her regular caseworker duties on March 1, 2010. A month later, she began experiencing pain shooting through both of her arms. She reported her symptoms to her supervisor, Ms. Pittman. On April 5, 2010, she signed a Form 45 indicating she injured her left ring and right middle fingers and developed bilateral carpal tunnel syndrome on March 24, 2010 due to "repetitive use of keyboard and writing." RX 3.

Petitioner returned to Dr. Gelman on April 15, 2010. In his note of that date, the doctor indicated Petitioner presented "with new complaints distinct from" her prior right ring finger problem. He indicated that Petitioner complained of paresthesias in the median nerve distribution of both hands, right more than left, nocturnal paresthesias every night and dropping objects. On examination, he noted a markedly positive Tinel's over the median nerve at the carpal tunnel bilaterally, a positive Phalen's test bilaterally, triggering of the left ring

finger and triggering of the right middle finger. He described the triggering as "severe, with locking." In light of these symptoms, and the prior surgery, he recommended that Petitioner undergo surgery rather than an initial course of conservative care. He suggested that Petitioner initially undergo a left ring finger trigger finger release and left carpal tunnel release and later undergo a right middle finger trigger finger release and right carpal tunnel release. He also indicated he completed an initial workers' compensation report and work status report. On these forms, he described the "history (description of accident) as "N/A" and restricted Petitioner to limited grasping, squeezing and carrying. PX 4.

At the next visit, on May 27, 2010, Dr. Gelman noted that Petitioner reported "some increased symptomatology with keyboarding." [Petitioner did not testify to having resumed working at this point. She testified Respondent was not able to accommodate the doctor's restrictions.] He also noted he was still awaiting authorization of the proposed surgeries. He added a work restriction of limited keyboarding. PX 4.

A work status report in Dr. Gelman's records reflects that Bob Dunlap of Respondent's CMS risk management division approved the proposed surgeries on June 21, 2010. PX 4.

On June 28, 2010, Dr. Gelman described Petitioner as "ready to proceed with surgery on the left hand." He indicated he made Petitioner aware "that the left hand may not do as well as the right." PX 4.

Records and bills in PX 4 reflect that Dr. Gelman performed a left carpal tunnel release and a left ring finger trigger release at Munster Same Day Surgery Center on July 8, 2010. The operative report is not in evidence. On July 19, 2010, Dr. Gelman released Petitioner to strictly right-handed work, indicating she should remain off if this kind of work was not available. He directed Petitioner to continue attending therapy.

On August 12, 2010, Dr. Gelman noted that Petitioner had made "marked progress in therapy" and exhibited no triggering or signs of carpal tunnel. He continued the right-handed work restriction. On September 3, 2010, the doctor directed Petitioner to continue therapy for three more weeks. On September 16, 2010, he noted more progress and continued the right-handed work restriction. On October 7, 2010, he released Petitioner to light duty with limited grasping, squeezing, carrying and keyboard usage. He indicated he planned to schedule the right-sided procedures. PX 4.

There is no evidence indicating Petitioner returned to Dr. Gelman after October 7, 2010.

Petitioner testified that a different physician, Dr. Rubinstein (of the Illinois Bone and Joint Institute), performed a right carpal tunnel release on January 27, 2011. No operative report of that date is in evidence. The doctor's bill (PX 1), however, shows an initial office visit of November 1, 2010 and a neuroplasty surgery on January 27, 2011. Therapy records in PX 4 show that Dr. Rubinstein performed a right middle finger trigger release on May 12, 2011.

The Illinois Bone & Joint records document an office visit of June 29, 2011, with the doctor noting some residual flexion contracture at the PIP joint and recommending ongoing therapy. On September 26, 2011, Dr. Rubinstein noted that Petitioner's flexion contracture was "working out" and that, with active and passive motion, he could almost get the finger corrected to zero. He released Petitioner to light duty, with no keyboarding, "as this would disrupt the balancing of her ligaments." On August 1, 2011, Dr. Rubinstein noted that Petitioner's progress had been delayed due to lack of approval for recommended hand therapy. He indicated Petitioner's finger was no longer triggering but that she still had a flexion contracture. He released Petitioner to restricted work using only the non-operated hand. On August 31, 2011, Dr. Rubinstein noted that Petitioner still had a flexion contracture of 5 to 10 degrees when fatigued. He released Petitioner to light duty with no typing or computer usage. On October 26, 2011, Dr. Rubinstein indicated that Petitioner was making progress in therapy. He noted full flexion and near full extension of "the finger," presumably referring to the right middle finger, but "a little bit of deficit with extension against resistance." He recommended that Petitioner continue therapy. He imposed restrictions of no grasping and no keyboard use. PX 6.

Records from Maximum Rehabilitation show that, as of December 1, 2011, Petitioner's right middle finger range of motion and right hand grip strength had improved. Petitioner was discharged from therapy on December 8, 2011 "due to other medical issues." PX 6.

Petitioner testified that, at some point, Dr. Rubenstein recommended an ergonomic keyboard but that Respondent never provided this equipment.

Petitioner testified she last underwent care for her injuries on January 3, 2012. [No treatment note of that date is in evidence.] She resumed her regular job duties thereafter and retired in 2015.

At Respondent's request, Petitioner underwent a Section 12 examination by Dr. Fernandez on August 26, 2014. Dr. Fernandez is a board certified orthopedic surgeon affiliated with Rush University Medical Center. RX 4 at 5.

Dr. Fernandez indicated he received and reviewed only a few medical records, including the right carpal tunnel release operative report, in connection with the examination. He also indicated he did not receive any job description.

Dr. Fernandez indicated that Petitioner provided a history of hand and finger symptoms dating back to 2004 which she associated with computer usage at her job. He stated that Petitioner described herself as "doing much better" following surgery and complained only of minor weakness primarily affecting her left hand and pain in cold weather. He noted that Petitioner had been off work since October 2013 due to a knee injury.

On examination, Dr. Fernandez noted "multiple well-healed surgical scars involving the right hand," some mild paresthesias in the left hand median nerve distribution, negative Tinel's,

Phalen's and median nerve compression testing bilaterally, generalized weakness in both hands, right greater than left, mild tenderness along the A1 pulleys diffusely in both hands, no active triggering or locking and a full range of motion actively and passively.

Dr. Fernandez obtained multiple X-rays of both hands and wrists. He interpreted the films as showing normal bone quality and alignment, with no evidence of fracture, dislocation or degenerative process.

Dr. Fernandez assessed Petitioner as having had a good response to the right carpal tunnel release and "some residual numbness and tingling on the left side consistent with possible carpal tunnel syndrome." [It appears the doctor was unaware Petitioner had already undergone a left-sided release.] He opined that the carpal tunnel and triggering would not be considered work-related "unless [Petitioner] was exposed to significant and/or forceful gripping or grasping or frequent extension and flexion through the wrist." He went on to state that "the simple tasks or activities of keyboarding and/or data entry not be considered causative or aggravating." He indicated his opinions could change if he learned that Petitioner performed forceful gripping and grasping "in more than one third or one half of the work day or work cycle with flexion and extension through the wrist, although very frequent in nature." He recommended observation of Petitioner's right hand and indicated Petitioner might require a left carpal tunnel release [again, it appears he was unaware she had already undergone this release.] He found Petitioner to be at maximum medical improvement and capable of full duty. RX 4.

On December 17, 2014, Dr. Gelman sent a report to Petitioner's counsel. In this report, he responded to various causation-related inquiries. He opined that Petitioner's right ring trigger finger condition stemmed from her caseworker duties since these duties involved bending the fingers. He stated that bending the fingers "can result in trigger finger." He characterized the triggering-related care as reasonable and necessary, as well as causally related to Petitioner's job. He also found causation as to Petitioner's bilateral carpal tunnel syndrome, stating that "repeated keyboarding and writing can result" in this syndrome. He characterized the carpal tunnel release surgeries as reasonable and necessary, as well as related to Petitioner's job. PX 7.

At some later point, apparently on December 30, 2015 (RX 6, p. 6), Dr. Fernandez issued an undated "IME Addendum," after reviewing a Form 45 dated April 19, 2010, a caseworker job description and Dr. Gelman's notes. He indicated that, according to the job description, Petitioner was required to lift 1 to 10 pounds less than three times per week, was never required to lift more than 10 pounds and used her hands for gross and/or fine manipulation approximately 2 to 4 hours per day. [The job description is not in evidence.]

Dr. Fernandez indicated that he considered the term "forceful gripping" to mean "gripping, grasping, pushing or pulling in excess of 20 to 40 pounds, particularly on a more frequent" basis. He stated the term did not refer to writing, typing or phone usage. He

indicated that, in general, the term was intended to refer to work that would cause calluses. He went on to state:

> "The only part that could be considered a possibility with regards to a data entry position will be if the individual was engaged in lifting and/or manipulating boxes of papers which could weigh in excess of 20 pounds two to three hours on a daily basis. This would be similar to archiving materials in a warehouse. There is no history of that here."

He further stated that flexion and extension of the wrists would have to be performed two to three hours per day to be considered frequent. He clarified that flexion and extension would typically be associated with use or a tool or machine and that "there would be no flexion/extension during keyboarding activities or writing." RX 5.

Petitioner testified she has never smoked and has never been diagnosed with diabetes or heart disease. Respondent paid all of her temporary total disability benefits and most of her medical expenses.

Petitioner testified her injuries affect her daily life and typical activities. Her left hand is weaker than her right. It is difficult for her to lift bags of groceries, wring out dish towels and brush her teeth and hair.

Under cross-examination, Petitioner testified that, as of March 2009, she spent about seven hours per workday in front of a computer. She spent about 75% of her time keyboarding and 60% of her time using a mouse. She wrote by hand occasionally, perhaps 15% of the time. She resorted to writing by hand when the computers went down or she had to complete an application for a client who was unable to do this on his own. Completing an application required filling in blanks, not writing out paragraphs. Before she submitted an application, via computer, she had to state her opinion as to why or why not benefits should be renewed. She sat in a regular office chair. The chair did not have arm rests. Her desk was about as tall as the counsel desks in the hearing room. Her work duties in 2009 were different than those she previously performed because she (and others) worked overtime, on certain Saturdays, to clean up the file room. Respondent offered this overtime twice monthly and she accepted the offer. She could not recall how often she performed this overtime. In 2010, there was no change in her work station, hours or duties. She was released to full duty as of March 1, 2010 and resumed full duty at that time. She was again released to full duty on January 3, 2012 and resumed full duty at that time.

On redirect, Petitioner described a Respondent case file as larger than a Commission case file. Each file contained information and documents, such as a birth certificate, pertaining to a particular client. The bulk of each file varied, depending on its contents. Respondent's file room contained thousands of files. Some of the files were in cabinets, where they were

supposed to be. Others were on the floor or stacked on top of the cabinets. When she and others worked overtime, their goal was to put all of the files into cabinets. A cabinet could be as tall as 6 feet, if you included the files that were typically stacked on top of it.

Arbitrator's Credibility Assessment

Petitioner's lengthy tenure with Respondent weighs in her favor, credibility-wise. Petitioner's description of her duties and the condition of the file room was detailed and unrebutted.

Overall, the Arbitrator found Petitioner very credible.

Arbitrator's Conclusions of Law Relative to Both Claims

Did Petitioner establish repetitive trauma injuries manifesting on March 27, 2009 and April 1, 2010? Did Petitioner establish a causal connection between said injuries and her current claimed right ring finger and bilateral hand/wrist conditions of ill-being?

In **09 WC 15218,** the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on March 27, 2009. The Arbitrator views March 27, 2009 as an appropriate manifestation date based on Petitioner's testimony as to the locking she experienced and the notice she provided on that date. The Arbitrator further finds that Petitioner established a causal connection between her repetitive trauma injuries and her current post-operative right ring finger condition of ill-being. In so finding, the Arbitrator relies on Petitioner's credible description of her duties, her credible account of the events of March 27, 2009, her credible denial of possible contributing systemic disorders such as diabetes, the records of Drs. Tansey, Wiesman and Gelman and Dr. Gelman's report. Dr. Gelman opined that triggering can be caused by bending the fingers. Petitioner would have had to repeatedly bend her fingers in order to keyboard, hold a phone or writing implement, move a computer mouse or extract a file from a stack. The Arbitrator notes that Respondent's examiner, Dr. Fernandez, did not question the trigger finger diagnosis and acknowledged he received only a few treatment records. Dr. Fernandez based his causation-related opinions on the assumption that Petitioner's job duties were limited to keyboarding, using a phone and "simple administrative tasks." He conceded that forceful gripping could contribute to the development of trigger finger and carpal tunnel syndrome but saw no evidence that Petitioner performed such gripping. At no time did he express any awareness of the condition of Respondent's file room or the fact that Petitioner was regularly required to pull files out of stacks and drawers in this room. Nor did he express any awareness of the duties Petitioner performed while helping clean the file room. He reviewed a job description, which is not in evidence, but there is no indication that this description accurately reflected Petitioner's duties insofar as file retrieval and lifting were concerned. Petitioner testified to having to retrieve and carry at least 10 to 15 client files per workday. She also testified to handling and rearranging files approximately sixteen hours per month while working overtime in 2009. No one rebutted her testimony that she was required to extract files from stacks and drawers.

In **10 WC 13841**, the Arbitrator finds that Petitioner established repetitive trauma injuries manifesting on April 1, 2010. The Arbitrator further finds that Petitioner established a causal connection between those injuries and her current post-operative bilateral carpal tunnel syndrome condition of ill-being. In so finding, the Arbitrator relies on Petitioner's credible description of her duties, her credible denial of possible contributing systemic disorders such as diabetes, the records of Drs. Gelman and Rubenstein and Dr. Gelman's report. The Arbitrator declines to rely on the causation opinions voiced by Dr. Fernandez, applying the analysis set forth in the preceding paragraph. The Arbitrator recognizes that Petitioner was off work during part of 2009 and had been back to work for only a month before she reported carpal tunnel symptoms. The Arbitrator finds it likely that these symptoms actually began before April 2010 but were overshadowed by the significant right ring finger problem.

Is Petitioner entitled to reasonable and necessary medical expenses?

The Arbitrator has previously found in Petitioner's favor on the issues of accident and causal connection.

Petitioner seeks an award of three medical bills totaling $8,594.65. PX 1. The Arbitrator recognizes that the payment of benefits is not an admission of liability but finds it ironic that the claimed bills relate to surgeries Respondent pre-authorized. Two of the bills relate to the August 12, 2009 surgery and the third relates to post-operative therapy rendered in 2011. The Arbitrator also notes that at no time did Respondent's examiner, Dr. Fernandez, question the necessity or reasonableness of Petitioner's care. RX 4-5.

In 09 WC 15218, the Arbitrator awards Petitioner Dr. Wiesman's bill in the amount of $3,189.82, subject to the fee schedule and with Respondent receiving credit for any payments it may have made toward this bill. [RX 6, a payment print-out, shows a payment for treatment rendered on August 12, 2009 but it is not clear whether this payment was made to Dr. Wiesman.] This bill relates to the trigger finger surgery of August 12, 2009 and several post-operative office visits through September 29, 2009. The Arbitrator also awards Petitioner the Windy City Anesthesia bill in the amount of $1,680.00, subject to the fee schedule. This bill relates to the anesthesia administered during the August 12, 2009 surgery. PX 1. Respondent's print-out (RX 6) does not reflect any payments to Windy City Anesthesia.

In 10 WC 13841, the Arbitrator awards Petitioner the Illinois Physicians Network bill of $3,724.83, subject to the fee schedule and with Respondent receiving credit for any payments it may have made toward this bill. [RX 6 shows various 2013 payments to Illinois Physicians Network for therapy rendered between August 2, 2011 and November 11, 2011.] This bill relates to therapy rendered in 2011.

What is the nature and extent of each injury?

Both claims are pre-amendatory since the injuries manifested prior to September 1, 2011.

In **09 WC 15218,** the Arbitrator awards permanency equivalent to 30% loss of use of the right ring finger, equivalent to 8.1 weeks of benefits. In making this award, the Arbitrator notes that the first surgery, performed by Dr. Wiesman, did not relieve Petitioner's symptoms and that, in his "re-do" operative report, Dr. Gelman described the A2 pulley as " partially destroyed." The Arbitrator also relies on Petitioner's credible testimony concerning her ongoing triggering.

In **10 WC 13841,** the Arbitrator awards permanency equivalent to 12.5% loss of use of the right hand (25.625 weeks) and 15% loss of use of the left hand (30.75 weeks), a total of 56.375 weeks. [The Arbitrator notes that, in 10 WC 13841, Petitioner did not seek permanency for any body parts other than her hands.] In making this award, the Arbitrator relies in part on the records of Drs. Gelman and Rubenstein. The Arbitrator awards a slightly higher percentage of loss for the left hand based on Petitioner's testimony and Dr. Fernandez's examination findings. Dr. Fernandez saw Petitioner <u>after</u> the left carpal tunnel release but did not know the release had been performed. He noted ongoing symptoms of left carpal tunnel syndrome and indicated Petitioner might need surgery. His findings support Petitioner's testimony as to ongoing left-sided symptoms.

STATE OF ILLINOIS)
) SS.
COUNTY OF JEFFERISON)

☐ 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

PHYLLIS PARKHILL,

Petitioner,

17IWCC0516

vs

00 WC 4373

MANPOWER,

Respondent.

DECISION AND OPINION ON REVIEW PURSUANT TO §8(a)

This matter comes before the Commission on Petitioner's Petition for Review Pursuant to Section 8(a), and Respondent's subsequent Motion to Compel a Section 12 Examination or Dismissal. Respondent apparently did not pursue its Motion to Dismiss or to compel another Section 12 examination and argues only that Petitioner's Petition for additional medical treatment be denied. A hearing was held in Mt. Vernon on March 20, 2017 before Commissioner Mathis. The parties were represented by counsel and a record was taken. The underlying claim was settled by contract approved by the Commission on June 24, 2003. Under the terms of the contract, Petitioner received $150,000 and a handwritten addendum to the rider indicated "medical is to remain open for reasonable & necessary care provided by Hamilton County Rural Health Clinic" "or referrals from that provider."

Findings of Fact & Conclusions of Law

1. Petitioner testified that she continued to have problems with her back after the settlement contract. She sought pain management treatment with Dr. Feinberg and had two additional surgeries performed by Dr. Robson. He had performed the initial surgery as well. The last surgery and pain management treatment were beneficial. Injections would stop her pain for two or three months.

2. On cross examination, Petitioner agreed that she saw somebody named Trotter at Hamilton County Community Health Center, who is her general practitioner. Ms. Trotter works at an OB/GYN office. Petitioner sees her every three months, but not for any condition related to the November 18, 1999 accident. Petitioner was initially referred to Southern Illinois Pain Management by Respondent. Petitioner denied ever having chiropractic treatment after the settlement. She learned about Dr. Feinberg from Dr. Robson.

3. She agreed she saw Dr. Wayne for a Section 12 examination a couple of months after the last surgery. At that time she reported no relief after the surgery, but "it hadn't worked yet."

4. On December 2, 2003, Petitioner presented to Dr. Robson, the surgeon who initially operated on her lumbar spine, for a repeat evaluation. He had previously released her at maximum medical improvement on January 24, 2002. Since then she had treated with her general practitioner and workers' compensation apparently agreed for this reevaluation by Dr. Robson. She had not worked since his previous examination and had accepted Social Security Disability. She complained of low back pain but no specific leg symptoms. X-rays showed solid fusion at L4-5 with no significant juxafusional internal changes at L3-4. Dr. Robson noted that a 2002 CT showed no significant problems but there was a disc bulge at L3-4, the level above the fusion. Dr. Robson recommended a repeat CT because of Petitioner's persistent symptoms. He also recommended increased physical activity in a community exercise program but did not believe Petitioner would benefit from formal physical therapy or chiropractic treatment, which she had previously.

5. On October 14, 2004, Dr. Robson noted the CT showed some juxafusional stenosis at L3-4 with some abnormal movement on flexion/extension. Dr. Robson thought she was developing some juxafusional stenosis. He offered an epidural steroid injection, but she declined because of a bad experience. He advised her about exercise and weight loss, and gave her Darvocet for break-through pain if the Ultram did not cover it.

6. On May 19, 2005, Petitioner reported to Dr. Robson increasing low back pain with intermittent leg pain with increased activity. X-rays showed no significant interval changes. Dr. Robson noted Petitioner had multilevel degenerative disc disease with some mild stenosis above her fusion. He thought that was the source of her pain. She had difficulty tolerating pain medications. He would try Percocet and if that did not work she might consider pain management. He did not think surgery was indicated.

7. On August 17, 2005, Petitioner presented to Dr. Goldberg on referral from Dr. Robson. She reported the onset of lower back pain in November 1999 from an accident at work "when she twisted and went down." The pain was 5-10/10 (usually 5/10) and radiated into the coccyx with occasional burning in the front of the legs. Dr. Robson performed fusion in May 2000, but it failed. A revision was performed in

November 2000, which succeeded. Petitioner reported she had progressive degenerative changes. Dr. Feinberg noted bilateral sacroiliac dysfunction, left much worse than right, and administered an injection in the left sacroiliac joint.

8. Petitioner continued to treat extensively with Dr. Goldberg. On August 2, 2007, Petitioner returned to Dr. Robson on referral from Dr. Feinberg. She reported she had not really been responding to his treatment. He noted that the CT showed high-grade stenosis at L3-4 and mild stenosis at other levels. Dr. Robson recommended removal of hardware, laminectomy and extension of the fusion to L3. Petitioner would consider the recommendation.

9. On January 16, 2008, Dr. Robson and Dr. Kennedy performed hardware removal, exploration of L4-5 fusion, bilateral laminectomies/facetecomies/foraminotomies L3-5, posterior fusion at L3-4, and spinal instrumentation L3-5 for juxafusional spinal stenosis L3-4.

10. On January 15, 2009, Petitioner continued to complain to Dr. Robson of lower back pain, but no significant radicular symptoms. Dr. Robson indicated that injections and pain management managed her condition well. Dr. Robson recommended she treat with Dr. Feinberg for chronic pain management.

11. Petitioner continued to treat extensively with Dr. Feinberg. On February 7, 2011, Dr. Feinberg noted that Petitioner had been referred to him by Dr. Robson for "postlaminectomy syndrome and lumbar radiculopathy with muscoskeletal mechanical complaints." He had first seen her on August 17, 2005 and she was treated with injections and Duragesic patches. She had seen Dr. Wayne for a Section 12 examination and "the request is made for evaluation of the patient's need for future medical treatments." Dr. Feinberg indicated that it was.

12. Petitioner continued to treat with Dr. Goldberg. His office renewed her medications for narcotic medication on numerous occasions through September 12, 2016. She also appears to have received about 19 injections at Dr. Goldberg's office between August 17, 2005 and April 28, 2009.

13. On March 24, 2015, Petitioner presented to Dr. Robson with "pain low back syndrome." She last saw Dr. Feinberg four to five years previously and "gets meds." When he last saw her in January 2009, she was doing well without significant radicular complaints. Her condition was being treated well by Dr. Feinberg. She had not had treatment for the last six years and was still reporting low back pain radiating into her legs bilaterally, right worse than left, and was having difficulty with balance. Dr. Robson recommended a CT Myelogram to determine a treatment plan.

14. Petitioner continued to treat with Dr. Robson and to complain about 7/10 low back pain, radiculopathy, and numbness/tingling. She had the CT, the results of which were pending, but it appears that Dr. Robson talked to the radiologist. Dr. Robson

diagnosed instability with severe degenerative disc disease at L1-2 and L2-3, which failed conservative treatment. He recommended hardware removal, lumbar laminectomy to relieve stenosis, and extension of fusion to L1.

15. On July 31, 2015, Dr. Robson performed hardware removal, exploration of L3-5 fusion, bilateral laminectomy at L1-2, L2-3, posterior fusion L1-3, with autograft/instrumentation L1-5 for spinal stenosis L1-3 and post fusion L3-5.

16. She returned to Dr. Robson on September 8, 2015. He noted that Petitioner still complained of 7/10 pain 1.5 months post fusion. She reported difficulty walking or standing for long periods. X-rays showed that the fusion was healing. Petitioner was to continue to get pain medication from Dr. Feinberg.

17. Petitioner continued to treat with Dr. Robson. On November 3, 2015, she complained of 9/10 pain, but "overall she was doing better," and "clinically, she was the same." She was still treating with Dr. Feinberg for pain management. Dr. Robson provided her with a home exercise program. On February, 2, 2016, Petitioner reported her back had improved and she now had 4/10 pain and increased tolerance to activity. Dr. Robson released her prn and noted she would continue to treat with Dr. Feinberg.

18. On March 21, 2016, in response from a query from Petitioner's lawyer, Dr. Robson opined that all the treatment Petitioner received, including surgery and pain management with Dr. Feinberg were "a progression stemming from her original injury of November 18, 1999."

19. Dr. Feinberg testified by deposition on December 9, 2011. He is board certified in anesthesiology and pain management. He estimated that currently about 5% to 10% of his practice involves workers' compensation, about 50% of his patients overall were referred by other doctors, and 50% were referred by "word-of-mouth."

20. Dr. Feinberg first saw Petitioner on August 17, 2005 on referral from her "fine surgeon," Dr. Robson. She reported a work injury to her low back in November 1999. Dr. Robson attempted a fusion in May 2000, which resulted in nonunion. A repeat surgery in November 2000 was successful.

21. Petitioner developed "chronic pain problems." When he saw her in 2005 she was complaining of 10/10 pain. She referred to herself as "disabled." She was inactive and gained weight from 162 pounds at the time of surgery to over 200 pounds at the time he saw her. She reported injections, but none since the second surgery.

22. After his examination, Dr. Feinberg diagnosed lumbar radiculopathy, post laminectomy syndrome, and sacroiliitis. The treatment plan was to administer an injection in the sacroiliac joint, which he did. At the next visit, Dr. Feinberg prescribed the lowest dosage Duragesic, which is a Fentanyl patch, and reinjected the sacroiliac joint due to continued hip and lower back pain.

23. Dr. Feinberg also testified he is "up on the latest techniques for pain management." He followed the protocol when prescribing pain medication to ensure proper usage and to determine correct medications and dosages. His diagnoses did not change. He tried to control her pain through minimum dosage of narcotics, along with Ultram, which had narcotic characteristics but is not classified as a narcotic and which had anti-inflammatory properties. He also administered injections as needed. When the sacroiliac joint injections were not beneficial he would use transforaminal injections.

24. As Petitioner's treating doctor, Dr. Feinberg disagreed "completely" with Respondent's Section 12 medical examiners, Dr. Graham and Dr. Wayne, who opined that Petitioner did not need pain medication or injections. Her high level of pain was "substantiated as far as sources on examination." Such pain is extremely common after two surgeries.

25. Petitioner continued to have problems above the level of the fusion so Dr. Feinberg discussed with Dr. Robson consideration of a CT. His treatment shifted from the sacroiliac joint to the levels above the fusion. Dr. Feinberg opined that Petitioner's condition of those disc levels was "juxtafusional, which means the levels that are adjacent to the fusion degenerative process so that it's related, that it is a normal *sequelae*, of the fusion surgeries."

26. Petitioner's condition continued to worsen and Dr. Robson performed the third surgery. Petitioner was sent back to Dr. Feinberg for chronic pain medications. There had been some talk of a multidisciplinary pain management program, but none existed in St. Louis. Dr. Feinberg "felt that the patient had done well with her treatment level, had maintained a much higher level of functional capacity than she would have if she were not treated and [he] made no recommendations to change the care." However, the workers' compensation insurer stopped authorizing injections and he agreed to evaluate her treatment on a quarterly basis because of the distance she had to travel and to reduce costs. If she lived closer he would see her more often and put her in supervised physical therapy. All his bills from August 2008 through June 28, 2010 were paid by Respondent. Dr. Feinberg opined that all the treatment he provided Petitioner was a result of November 1999 injury.

27. On cross examination, Dr. Feinberg testified Petitioner lived about three and a half hours away and she travels by car. He was sure there were pain management doctors closer to her home. It looked like the last time he personally examined Petitioner was April 28, 2009. His diagnosis was still laminectomy syndrome, but her sacroiliitis was much less. Dr. Feinberg believed that prior to the last surgery, the primary source of Petitioner's pain was the left sacroiliac joint. Petitioner then developed instability in the level above the fusion resulting in problems in the facet levels of L4-5. "After the surgery her primary complaint, even though she had some sacroiliac dysfunction, was really at the level and just above the level of the L3-4 fusion."

28. Dr. Feinberg explained that a fusion places greater pressure on adjoining levels that had not been fused. Pain can be present without any observable objective findings. He was not aware of any psychological evaluation Petitioner had. He does at times prescribe such evaluations most commonly "because of associated anxiety and depression disorders with chronic pain problems." He could also recommend such evaluation when required for an implant or when there is no objective evidence for pain problems. He believed Petitioner had problems with anxiety and depression. He agreed that physical therapy can help to break the pain cycle and he never prescribed physical therapy for Petitioner in his pain management regimen. He agreed that pain management is not simply medication oriented and "should encompass the whole individual."

29. Dr. Robson testified by deposition on October 6, 2016. He is an orthopedic spine surgeon who is board certified. When he saw Petitioner on March 24, 2015 she reported that she had done well after his surgery in 2000 until he last saw her in 2009. She did not have significant leg complaints and her pain was well managed. He had previously released her from treatment to the care of "the Feinbergs" on February 2, 2006 for pain management. However, over the past few months she had trouble walking, had a couple of falls, developed radiating leg pain, and was worried about her decline in function and wanted him to evaluate her condition. X-rays showed "some pretty significant changes at the L1-2 level and at L2-3."

30. Dr. Robson recommended a CT/Myelogram. That test showed "significant retrolisthesis, which is an offset at L1-2, foraminal stenosis, and changes with collapse and severe narrowing at L2-3." The fusion at L3-5 seemed solid. He recommended and performed surgery in July of 2015.

31. Dr. Robson explained that she had an initial injury in 1999 which required a spinal fusion at L3-5. That fusion created a lever and stress at adjacent levels which can cause degeneration and arthritis quicker than normal; "it's well documented." She developed "a big offset and instability at L1-2" which caused her symptoms reported in March 2015. He considered the opinion of one of Respondent's Section 12 medical examiners about the impact of fusion on adjacent levels is controversial to be "crap." Dr. Robson had "never seen anybody say it doesn't happen." The condition he treated in 2015 was caused by the initial fusion and therefore related to her initial accident/injury. The instance of problems at L1-2 and L2-3 independently of other lumbar levels is "really rare."

32. On cross examination, Dr. Robson agreed that when he first saw Petitioner she had preexisting severe degenerative issues with her spine. Such a condition continues to worsen even absent trauma; that's "what the term degenerative implies." She also had scoliosis, "which probably hastened her instability above." However, as he recalled she was asymptomatic prior to her 1999 accident/injury. Dr. Robson does not fuse asymptomatic people. He agreed that Petitioner was not following his recommendations about exercise and fitness.

33. On redirect examination, Dr. Robson testified that all the surgeries he performed on Petitioner were related to the original accident/injury in 1999. She then developed adjacent level problems which occur in from 10% to 20% of the time.

34. Dr. Graham testified by deposition on December 16, 2011. He has specialized in pain management exclusively since 1996. His practice was winding down because he was retiring at the end of the year, but previously he saw probably between 50 and 70 patients a week and less than 5% of his practice involved independent medical examinations.

35. He saw Petitioner for a Section 12 examination on June 27, 2011. When initially asked about her complaints, Petitioner responded "everything." When asked to be more specific she indicated she had low back pain from the waist down with achy sensation in her legs, right worse than left. "The symptoms and locations varied from day to day." Her pain was currently 10/10 and averaged 7/10. Extended walking/standing exacerbated her pain. She reported driving, cooking, laundering, gardening, painting, crocheting, and taking care of her grandkids. Her family helped with cleaning. She was currently taking Ultram, a nonnarcotic/quasi narcotic pain killer, and Duragesic, a Fentanyl skin patch.

36. On examination, Petitioner was able to change positions unassisted and with ease. She was able to get on and off the examination table. Range of motion in her back was full with no spasm or trigger points. Deep tendon reflexes were symmetrical, single leg raises were negative bilaterally, and neurological findings were negative. However, her "psychological screen exam showed clinical range somatization and obsessive-compulsive scales, elevated depression, anxiety and phobic anxiety."

37. Petitioner's pain questionnaire indicated her pain was functionally debilitating including the ability to raise her arms overhead. That was in contrast to observations at examination in which she was able to ambulate without a limp and squat and bend at the waist without difficulty. He characterized her responses regarding her arm dysfunction as "non-physiologic." In his opinion, there was no indication for the injections therapy, including sacroiliac joint, facet, and transforaminal injections, that were administered.

38. Dr. Graham explained that there was no evidence of any sacroiliac joint pathology. Physical exam for sacroiliac joint pathology is notoriously inaccurate and a recent study "found that there was lack of sufficient evidence to show benefit from sacroiliac joint injections." In this case the sacroiliac injections did not provide lasting relief. The same study also questioned the efficacy of facet injections.

39. In addition, the indication for transforaminal epidural steroid injections is new, acute radiculopathy, and there was no evidence that Petitioner had pathology causing radiculopathy, she did not show a dermatomal distribution of pain, Dr. Robson's examinations of Petitioner's legs were normal, and Dr. Feinberg did not document

any specific radicular symptoms. Finally, Dr. Graham did not believe that chronic use of narcotics was indicated for subjective complaints without objective findings; it had been documented that her fusion was successful. He also noted that the use of the Duragesic patch did not comply with recommendations of the drug manufacturer or the FDA. He also did not believe the criteria for the third fusion surgery had been met.

40. Dr. Graham also testified that juxtafusional stenosis is a "theory that has come under disagreement recently." "Now there's (*sic*) papers out there that are indicating that there's no solid evidence to support that it is a proven theory, that there could be other reasons why one could have pathology at that level other than the prior fusion surgery." Dr. Graham noted that the treatment provided Petitioner had failed, and therefore, there is no indication that such treatment should continue. The only prospective treatment Petitioner should have would be to wean her off the narcotic medication which was not effective anyway.

41. On cross examination, Dr. Graham agreed that Petitioner could have had pain after the fusion, but there was no evidence of radiculopathy either radiographically or clinically. He also agreed that in the past he had prescribed both chronic pain medication and injections for patients, when appropriate. Currently, the literature suggests that injections should be used for acute conditions and not chronic conditions.

42. Dr. Graham explained that somatization was a psychological condition that Petitioner has, which is not caused by medical treatment; "it's just part of her makeup. It's how she processes information." He recommended light duty, with a 25-pound restriction, because of her two-level fusion not because of her subjective complaints. He has prescribed Ultram in the past and it generally relieves pain and improves functionality.

43. Dr. Wayne testified by deposition on December 16, 2011. He is board certified in orthopedic surgery. He first evaluated Petitioner on November 16, 2001 and reviewed her medical records. She presented with a "failed lumbar surgery syndrome following May and November 2000 laminectomy/fusion procedures" at L4-5. She also had considerable degeneration at L3-4 and L5-S1 as well as a disc bulge at L2-3. Dr. Wayne concluded that her complaints were not the result of her accident but rather her preexisting disease. He did not believe additional surgery was indicated and that she should "eliminate the use of any dependent-provoking drugs such as Talwin which she was utilizing at the time."

44. Dr. Wayne saw Petitioner again on August 24, 2010. She indicated that in 2008 she had a third fusion surgery for lower back and left leg pain. Her pain gradually returned and she reported a series of what she described as trigger point injections. She was also using Ultram and Fentanyl patches and was under the treatment of Dr. Feinberg for pain management.

45. Petitioner also reported constant pain in her lower back that ranged from 3/10 at best to 10/10. She rated her current pain as 10/10 which was not consistent with her demeanor and behavior. She was able to drive short distances but could not perform household chores. She could only sit/stand for 15 to 30 minutes before she would have to lie down and use heat.

46. His examination appears to have been normal. Her pain complaints did not correlate with his physical examination. While she exhibited subjective complaints consistent with failed three time lumbar surgery syndrome, objectively she had excellent decompression and fusion at L3-4 and L4-5. His examination also showed no signs of facet or sacroiliac joint dysfunction. He also noted that "there is a past history of findings suggestive of depression and anxiety disorder and a current concern of narcotic dependency." The only prospective treatment he recommended was a bone density test and "psychiatric evaluation and possible psychometric testing." He did not agree with the diagnosis put forth by Dr. Feinberg.

47. Dr. Gill testified by deposition on November 12, 2012. She is board certified in anesthesiology. She is a clinical anesthesiologist at Ophthalmic Consultants of Boston, an eye surgery center, but does that one day a week while she does utilization reviews the other four days. She did several reviews of treatment and proposed treatment for Petitioner. In October 2008 she was asked to evaluate the efficacy of sacroiliac joint/hip injections. She wrote that they were not because there was no response noted after two previous injections and there "were no exam findings supporting doing anything." She tried to make phone contact twice but never got a response from the treating doctor.

48. Dr. Gill also testified she uses the Official Disability Guidelines in making her determinations. That guide requires the failure of conservative care, such as physical therapy or chiropractic treatment and such treatment was not documented. In addition, there has to be some findings that make one suspect that the sacroiliac joint/hip is the source of the symptoms. Finally, the guides suggest frequency of injections be two months apart or longer and each injection should provide relief for six weeks. Typically, these injections should not be used in conjunction with other injections because then it would be difficult to determine which injections were beneficial, and it is recommended no more than four steroid injections a year.

49. In May 2009, Dr. Gill was asked to review a third set of lumbar facet injections. She did not believe it was reasonable because the treating doctor had already done two and reported 40% relief in total. She noted that facet injections are normally a diagnostic tool to determine whether ablation is warranted. The 40% relief rate would be considered sub-par and therefore a "negative" diagnostic and therapeutic injection. Again she called the treating doctor twice, did not make contact, and her calls were not returned. She recommended a home exercise program and medications in *lieu* of the injections.

50. In June 2009 she was asked to review a request for radiofrequency ablation. She concluded it was not indicated for the same reasons she recommended against the injection, the response to the injections were not adequate to warrant ablation. She also noted that in fusion the facet joints are destroyed which would also preclude facet injections. However, there was no indication from the treating doctor's noted what level he proposed to ablate.

51. On February 11, 2010, Dr. Gill was then asked to review the efficacy of more sacroiliac joint/facet injections. Again, she determined that they were not because there were no findings suggesting the sacroiliac joint was a problem and doing sacroiliac injections in conjunction with facet joint injections is not indicated because they are so close to each other that would be impossible to determine which injection was beneficial. Attempts to contact the treating doctor for more information were unsuccessful.

52. On cross examination, Dr. Gill testified she was not provided any MRI studies; if she had she would have noted that. She could not recommend specific medications for Petitioner because she did not know what she was taking and did not even have an exam to determine what her problem is. All she knew was that she had fusion surgeries, potentially at two levels and she had hip pain.

53. Dr. Fejos testified by deposition on January 23, 2015. He is board certified in pain management and physical medicine/rehabilitation and works at Orthopedic Associates of Middletown (Conn.) in interventional pain management. He administers facet block injections in his practice. He also performs utilization reviews and did one regarding a third set of facet injections recommended for Petitioner. He knew he tried to contact the treating doctor and he thought he also did on the next day, and left messages. The documents he reviewed indicated that Petitioner had two previous facet injections which provided 30 to 40% relief. Patients should have at least 50% relief to have radiofrequency ablation performed. Facet blocks are diagnostic and not therapeutic. He recommended consideration of ablation as an option of last resort because she had almost 50% relief.

54. On cross examination, Dr. Fejos agreed that he never practiced in Illinois or Missouri, but the standard of care should be the same. He did not believe Petitioner needed any additional facet injections but he was not asked to determine whether or not she needed any medical treatment at the time. He makes determinations as a pain doctor and not as a neurologist or orthopedist.

55. Dr. Fejos opined that the proposed treatment was not within the standard of care prescribed by the American Society of Interventional Pain Physicians. He has treated patients outside the normal standard of care if he thought it was the right thing to do and the patient was completely aware of possible consequences. However, he would not recommend that to other doctors.

56. On redirect examination, Dr. Fejos testified he would not expect the standard of care would be different in different states. He reiterated that he denied the third facet injection because Petitioner only had 30-40% improvement and there was no indication that the doctor was using it as a diagnostic tool associated with possible ablation.

57. On re-cross examination, Dr. Fejos testified he did not know whether individual doctors strayed from guidelines. He reiterated that facet block injection had no therapeutic value. Patients are injected with short-term anesthetic to determine the source of pain and steroids do not have a therapeutic effect on medial branch nerves. It may reduce swelling, but that is not the problem. Nerves are being injected not joints.

In the instant proceeding, Petitioner seeks only payment of all current outstanding medical amounting to about $75,000. She does not ask for an award of prospective medical. Petitioner argues the treatment was all done to treat her work injury and that Dr. Robson and Dr. Feinberg were "within the chain of referrals." Respondent argues that the Commission should not award outstanding medical because Petitioner did not establish that Dr. Robson and Dr. Feinberg were referred by Hamilton County Rural Health Clinic, as specified in the settlement contract. In addition, it stresses that the treatment rendered was neither necessary nor reasonable, citing the opinions of its medical examiners and utilization review doctors. In addition, it notes that Petitioner continually reported severe pain throughout treatment supporting the conclusion that the treatment was neither reasonable nor necessary. Respondent simply asks that "any additional treatment be denied."

First, the Commission considers Respondent's argument that it should not be liable for the medical treatment rendered to Petitioner because she did not establish that such treatment was performed on referral from Hamilton County Rural Health Clinic, as specified in the settlement contract. Dr. Robson was Petitioner's treating surgeon prior to the settlement contract. When Respondent agreed to the keep medical open indefinitely, it should have foreseen that such treatment would likely include additional treatment from her surgeon. In addition, it paid much of the medical bills for Petitioner's continued treatment and specifically paid Dr. Feinberg's bill up to June 28, 2010. If Respondent wanted to deny payment based on the lack of referral from Hamilton Health, it certainly could have demanded such a referral, which Petitioner almost certainly would have been able to obtain.

Second, the Commission considers the issue of whether the treatment provided to Petitioner was necessary and reasonable. It seems likely that Petitioner has engaged in symptom magnification, whether intentionally or because of a psychological condition. For much of the last decade and a half she has reported 10/10 pain, which is contrary to her being at least partially functional throughout. The Commission certainly does not condone the chronic use of narcotic medication, especially when the efficacy of such treatments may be questionable. Nevertheless, despite her subjective reports of very limited improvement with treatment, and perhaps in light of her exaggeration of her pain, her treating doctors, Dr. Robson and Dr. Feinberg, apparently were convinced that their respective treatment was sufficiently beneficial to continue.

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Petitioner apparently had a total of four fusion surgeries, two in 2000 fusing L4-5, the third in 2005 extending the fusion to L3-4, and the fourth in 2015 extending the fusion to L1. At this point it appears her entire lumbar spine is fused and her continued pain seems understandable. While Petitioner subjectively noted limited benefit from her treatment, we do not know what her current condition would have been if no such treatment had been provided by Dr. Robson and Dr. Feinberg. The Commission recognizes that the testimony of Respondent's Section 12 medical examiners, Dr. Graham and Dr. Wayne, as well as Respondent's utilization review doctors, Dr. Gill and Dr. Fejos made some cogent arguments. However, we do not consider their opinions were more persuasive than those of Petitioner's treating doctors.

The utilization review doctors did not have specific knowledge of Petitioner's condition and the Section 12 medical examiners appeared to have completely discounted Petitioner's subjective complaints. On the other hand, Dr. Robson treated Petitioner from around 1999 up to the end of 2015 and Dr. Feinberg's office treated Petitioner from August 2005 through June of 2016. Therefore, the Commission finds these doctors were more intimately aware of Petitioner's condition, its progression, and perhaps Petitioner's particular subjective reaction to her pain/discomfort. The Commission stresses that providing medical treatment is not an exact science. Simply because treatment rendered did not result in a hoped for improvement does not necessarily mean that the treatment rendered was neither indicated nor reasonable. In this matter, the Commission places greater weight in the opinions of Petitioner's treating doctors over Respondent's utilization review and Section 12 doctors. Therefore, the Commission grants Petitioner's Petition under Section 8(a) of the Act.

IT IS THEREFORE ORDERED BY THE COMMISSION, that Petitioner's Petition pursuant to §8(a) of the Act is granted.

IT IS FURTHER ORDERED BY THE COMMISSION, that Respondent pay the outstanding bills submitted by Petitioner including $65,095.24 to Comprehensive Spine Care, $6,307.97 to IWP Pharmacy, $3,910.00 to Ballas Anesthesia, and $136.00 to Parkway Pathology pursuant to §8(a), subject to the applicable medical fee schedule in §8.2 of the Act.

Bond for the removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $75,000.00. 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 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-7/13/17
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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:	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

IVAN MAXWELL,

Petitioner,

17IWCC0517

vs. NO: 10 WC 8626

STATE OF ILLINOIS – VIENNA CORRECTIONAL CENTER,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review having been filed by the Petitioner herein and notice given to all parties, the Commission, after considering the issues of causal connection, permanent partial disability, and medical expenses both current and prospective, and being advised of the facts and law, reverses the Decision of the Arbitrator and finds Petitioner established that his current condition of bilateral carpal tunnel syndrome is work related. However, the Commission also finds that his bilateral cubital tunnel syndrome is not work related.

In a previous proceeding under Section 19(b) of the Act, Arbitrator Dibble found Petitioner proved a work-related motor vehicle accident and/or work-related repetitive trauma resulted in bilateral carpal tunnel syndrome and awarded medical treatment including prospective treatment. That 19(b) proceeding was consolidated with another claim, 08WC41341, in which Arbitrator Lee later awarded compensation of loss of 30% of the person-as-a-whole. The decision in that claim was not reviewed and that decision is not included in this file. The Application for Adjustment of Claim in 08WC41341 alleged a motor vehicle accident on August 26, 2008 and injuries to the back, shoulders, and neck. The instant claim alleged a repetitive trauma accident on June 23, 2009 with injuries to the hands. However, in the instant 19(b) decision, Arbitrator Dibble found that the motor vehicle accident was a causal factor in the bilateral carpal tunnel syndrome. Prior to the instant hearing the parties entered into a stipulation in which it was noted that the permanent partial disability in 08WC41341 was being adjudicated but would not include any compensation for the hands, wrists, or arms.

17IWCC0517

Findings of Fact & Conclusions of Law

1. Petitioner testified he was currently 39 years old and worked for Respondent as a corrections officer since 1999. He was involved in a motor vehicle accident in 2008 and at some point subsequently was diagnosed with carpal tunnel syndrome. He had bilateral carpal tunnel syndrome release surgery by Dr. Davis.

2. After the surgery, Petitioner had recurrent problems and had second bilateral surgery in 2013 by Dr. Young; "he also did [Petitioner's] elbows." Petitioner had some relief after the second surgeries. His hands will still "cramp up a little" when doing "tedious stuff." He also has to "watch hitting [the elbows] on stuff because it is immediate pain because there is nothing no more to protect it." Writing for extended periods aggravated his symptoms in the period between surgeries. His hands would also give out when twisting.

3. Petitioner agreed that as a corrections officer his job is "fairly hand intensive" and he has to use keys on doors "quite a bit throughout the day." Pretty much writing and use of keys are the job activities that aggravate his hands and arms. Currently, he still has occasional numbness and tingling in his hands and a loss of grip strength. He has a little bit of problems in flexing and extending his hands, but that has improved over time.

4. On cross examination, Petitioner estimated that his grip strength was probably about "three-quarters." When he is holding a clipboard his grip will become weak. His hand cramps when using nail clippers. Vienna is a minimum security facility and inmates have keys to their rooms but he has to unlock the door at the entrance of the unit. He guessed he unlocked such a door 25 to 40 times a day.

5. Petitioner also testified that the keys he generally uses are about three times the size of house keys, but are smaller than Folger Adams keys. He also opens closet doors and accesses log books by opening padlocks. He did not take prescription medication for his hands/arms, but he takes two to four over-the-counter Advil and Aleve a day. He did not take such medication daily prior to the accident. He still fishes but "right now it's been a struggle;" he tries to go about once a month. He had no plans to hunt this year. He doesn't "have time to deer hunt." He was "kind of upset about that."

6. The medical records reveal that on June 23, 2009, Petitioner presented to Dr. Davis for evaluation of pain and dysfunction in his left shoulder and left arm. His symptoms began on August 6, 2008 when he was injured in a rollover motor vehicle accident. He hit his left shoulder in the collision and again on evacuation. He had left L4-5 fusion in December 2008.

7. An EMG taken on July 8, 2009 showed evidence of moderate bilateral carpal tunnel syndrome, with no evidence of ulnar neuropathy.

8. Petitioner had left shoulder surgery on November 12, 2009 and he had left and right carpal tunnel release surgeries on March 16, 2011, and May 11, 2011, respectively.

9. After physical therapy, on February 28, 2012, Petitioner reported he still had some weakness and tingling, but thought he could return to work. Petitioner was released to work and from treatment.

10. On July 5, 2012, Petitioner presented to Dr. Young for "CMC arthrosis" and was still having numbness/tingling in fingers bilaterally. Dr. Young noted that Petitioner had done well after carpal tunnel release surgery but had increased numbness/tingling. He ordered an NCV.

11. On August 27, 2012, Dr. Young noted that the new NCV showed no change since 2009 and one would have expected improvement after surgery. They discussed treatment options and Petitioner wanted to proceed with surgery. In an appointment about a month later, Dr. Young indicated Petitioner would benefit from repeat carpal tunnel release and left ulnar transposition.

12. On July 10, 2013, Dr. Young performed left repeat carpal tunnel release and left ulnar nerve transposition for recurrent left carpal tunnel syndrome and cubital tunnel syndrome. On September 22, 2013, he performed the same surgeries on the right side.

13. On October 24, 2013, Dr. Young noted that Petitioner was doing very well. He was "going to turn him loose to full duty" and released him from treatment.

14. Dr. Young testified by deposition on September 9, 2014. He first saw Petitioner on December 29, 2011 for evaluation of bilateral thumb pain, left a little more problematic than the right. He was also complaining of numbness and tingling in some fingers. Previously that year he had bilateral carpal tunnel release by Dr. Davis. Dr. Young did not note activities that aggravated Petitioner's symptoms. Dr. Young prescribed medication, splints, and instituted a 10-pound lifting restriction. By February 28, 2012, Petitioner reported some improvement and felt he could return to work. At that time Dr. Young released him. Dr. Young thought the temporary improvement could have been the result of medication and restricted work duty.

15. Petitioner returned to Dr. Young on July 5, 2012 complaining of numbness and tingling in the ring and small fingers, which he complained about previously. The most common cause of such complaints is peripheral nerve compression such as carpal tunnel or cubital tunnel syndrome.

16. Dr. Young ordered an NCV of Petitioner's arms. The tests showed moderate median neuropathy, but "there was no indication in that particular exam that he did have the nerve compression at the elbow." After discussion about treatment options, Petitioner opted for surgery. Dr. Young thought there were sufficient subjective complaints to suggest nerve compression at the elbows despite the negative NCV test. He performed bilateral carpal tunnel release and ulnar transposition surgeries.

17. Dr. Young explained that the need for carpal tunnel revision surgery is "not an unheard of situation." In his first operative report from July 10, 2013, he noted substantial scar tissue adhered to the transverse carpal ligament and there "appeared to be substantial pressure persisting on the nerve at the proximal aspect of the carpal tunnel deep to the distal forearm fascia in the proximal aspect of the transverse carpal ligament." The scar tissue developed from the first surgery. Observation of the right side, convinced Dr. Young that there was "partial release or potentially incomplete release" at the initial procedure. He decided on "a more aggressive approach on the second" surgery.

18. When asked about causation, Dr. Young responded that Petitioner "had mentioned during one of his visits with us that whenever he would work with elbows in a flexed position his symptoms were aggravated. That would, in fact, be an exacerbating or contributing factor for ulnar nerve compression at the elbow." Dr. Young believed his work "could be" an aggravating factor in the condition of his elbows. He offered the same opinion regarding Petitioner's wrists.

19. On cross examination, Dr. Young reiterated that his left-sided surgery was required due to scar tissue while his right-sided surgery was required due to incomplete release from the initial surgery. He was unaware of Petitioner's work status when he performed the first carpal/cubital tunnel surgery. He believed it was fair to say that Petitioner eschewed conservative treatment *in lieu* of surgery. Dr. Young would have been fine with commencing conservative treatment, but he would not have performed surgery if it were not reasonable. There was some mention of Petitioner's work activities in an IME report.

20. Dr. Sudekum testified by deposition on June 16, 2015. He is board certified in plastic and reconstructive surgery with a certification in the subspecialty of upper extremity surgery. He still performs upper extremity surgery on a regular basis; typically at least several times weekly including carpal/cubital release surgeries. Respondent asked him to perform two medical examinations on Petitioner pursuant to Section 12 of the Act, one on January 9, 2012 and the other on November 6, 2014.

21. Dr. Sudekum noted that since his first examination and deposition testimony Petitioner complained of symptoms including intermittent pain, cramping, spasm, and weakness. Subsequently, he had a repeat NCV studies which revealed similar finding to the first NCV and he had repeat bilateral carpal tunnel release surgeries. That NCV showed no ulnar neuropathy. In fact the findings of the initial NCV, those of the study he performed at the first Section 12 examination, and the repeat NCV ordered by Dr. Young all had similar findings, except that Dr. Sudekum's test showed a "borderline finding" on the right ulnar nerve.

22. Dr. Sudekum agreed that Petitioner reported subjective symptoms between the carpal tunnel release surgeries. However, Dr. Sudekum did "not think that his symptoms as described in the notes leading up to his secondary carpal tunnel releases were indicative of significant median neuropathy or recurrent carpal tunnel syndrome."

23. Dr. Sudekum did not believe the symptoms or objective findings were sufficient to justify repeat carpal tunnel surgeries. Residual electrodiagnostic findings are not sufficient to justify repeat such surgery. In addition, his symptoms could be related to other conditions such as tendonitis, which should be treated conservatively.

24. In addition, Dr. Sudekum did not believe Petitioner had ulnar neuropathy that would be typical of cubital tunnel syndrome. The numbness and tingling in the ring and little fingers is very common and the presence of some symptoms of ulnar nerve irritation "is certainly not an indication for surgery," especially if the NCV did not show neuropathy.

25. On cross examination, Dr. Sudekum "wouldn't go so far to say" that the issue of his opinion regarding revision surgery and that of Dr. Young who performed the revision surgery, was whether one was absolutely correct and one was absolutely wrong. However, the symptomology associated with median nerve pathology is very well defined. He did not believe the symptomology justified the revision.

26. When asked about the efficacy of Petitioner's ulnar surgery, Dr. Sudekum noted that it was "an important judgement type of call." However, this kind of analysis is "almost always Workers' Compensation cases. We don't see this in Medicare. You don't operate on Medicare patients. You don't operate on cubital tunnels with normal nerve conduction studies." He also noted that ulnar surgery is quite a bit more problematic than CTS surgery in terms of risks.

27. In the previous decision in this claim issued pursuant to Section 19(b) on December 8, 2010, the Arbitrator found that Petitioner's condition of ill-being of bilateral carpal tunnel syndrome was caused by the accidents of August 6, 2008 (08WC8626 – motor vehicle accident) and/or June 23, 2009 (10WC41341 – repetitive trauma). In the body of that decision, the Arbitrator quoted from the deposition of Dr. Davis. He indicated that Petitioner told him he was gripping the steering wheel tightly at the time of the motor vehicle accident. He thought that that while that was not likely the sole cause of his condition, it "could be contributory for some pre-existing condition." Petitioner "said he did use his hands a lot at work and he had to turn keys and do all kinds of things and he thought he might have had some vague symptoms before but not specific and he said he didn't have any significant trouble until his" motor vehicle accident. He then opined that the collision "may have been" a contributory cause of his carpal tunnel syndrome. The Arbitrator then found that it was more likely than not that the motor vehicle accident aggravated pre-existing carpal tunnel syndrome complaints.

In the decision currently under review, the Arbitrator denied compensation because he found the testimony of Dr. Sudekum more persuasive than that of Dr. Young. The Commission agrees with the implicit assessment of the Arbitrator that Petitioner did not sustain his burden of proving the recurrent bilateral carpal tunnel syndrome was caused by Petitioner's alleged repetitively traumatic work activities, which is the theory of recovery in the Application for Adjustment of Claim. However, the Commission is constrained by the previous 19(b) decision in which the Arbitrator found the motor vehicle accident "more likely than not" aggravated a preexisting condition and contributed to his bilateral carpal tunnel syndrome.

17IWCC0517

That finding of the Arbitrator became the law of the case and is still applicable. Once that foundation has been established, the Commission finds Dr. Young's explanation regarding the need for revision carpal tunnel releases is reasonable. In surgery, he observed what he deemed to be scar tissue from the first surgery causing irritation in the left median nerve and an incomplete release on the right carpal tunnel.

At the same time, the Commission agrees that Petitioner did not sustain his burden of proving that any cubital tunnel syndrome was caused by his motor vehicle accidents or repetitively traumatic work activities. Petitioner was not diagnosed with cubital tunnel syndrome for years after the motor vehicle accident and there really is no objective evidence to corroborate the diagnosis. In addition, Dr. Young's opinion that Petitioner's work activities "could have" contributed to irritation of the ulnar nerve by flexing his elbows while working is neither definitive nor persuasive.

Finally, the Commission accepts Dr. Young's opinion that revision carpal tunnel release was reasonable and necessary. However, the Commission has found any alleged bilateral cubital tunnel syndrome was not related to Petitioner's work activities. Therefore, the Commission awards medical expenses associated with the revision carpal tunnel release but not the ulnar transposition surgeries performed to treat cubital tunnel syndrome.

In assessing permanent partial disability, the Commission notes that Petitioner was able to return to work at his normal job, which involves repetitive hand activities, he has not established any potential loss of earning potential, his complaints about current impairment/disability were relatively minimal, and there was little evidence in the medical records pointing to ongoing impairment disability. In looking at the overall record before us, the Commission finds that an award of loss of 12.5% of the dominant right hand and loss of 10% of the left hand is appropriate.

IT IS THEREFORE ORDERED BY THE COMMISSION the Decision of the Arbitrator dated January 22, 2016 is hereby reversed.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $600.97 per week for a period of 46.125 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the loss of the use 12.5% of the right hand and loss of 10% of the left hand.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay medical expenses related to Petitioner's revision bilateral carpal tunnel release surgeries under §8(a) of the Act pursuant to the applicable medical fee schedule, but Respondent is not liable for any medical expenses associated with the bilateral ulnar release surgeries.

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

17IWCC0517

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 18 2017

Deborah L. Simpson

David L. Gore

Stephen J. Mathis

DLS/dw
O-7/13/17
46

STATE OF ILLINOIS)
) SS.
COUNTY OF KANKAKEE)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Helen Brooks,
Petitioner,

vs.

No. 14 WC 4973

Kankakee School District 111,
Respondent.

17IWCC0518

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, medical expenses, temporary disability and permanent partial disability, and being advised of the facts and law, finds Petitioner did not prove her accident arose out of and in the course of her employment with Respondent, and reverses the Decision of the Arbitrator, which is attached hereto and made a part hereof.

Petitioner testified she worked for Respondent as a Head Cook II, preparing food for four different schools in the "Co-Op Building." Her usual hours at this job were 7:00 am to 1:30 pm. In January 2014, she also worked a second job as part of the "Fresh Fruit and Vegetable Program" at the Lincoln Cultural Center ("LCC"), a Montessori school in Respondent's district, bagging vegetables and preparing food for that school. She volunteered for that job, which was unrelated to her head cook job. She began that job at 2:00 pm, after driving there from the Co-Op Building.

At her primary job as a head cook in the Co-Op Building, Petitioner parked her car in the same spot in the lot every day, in an area where other employees typically parked. Although she was not aware of anyone from the general public who parked in that area of the lot, Petitioner was not required to park there and the space was not designated to her.

On January 14, 2014, after finishing her shift as head cook in the Co-Op Building and signing out, Petitioner slipped and fell in the icy parking lot walking to her car. She landed on her right side striking her shoulder, wrist, elbow, hip and knee. Petitioner was treated at St. Mary's, where she was x-rayed, authorized off work and referred to Dr. Eddie Jones. She saw Dr. Jones on January 16, 2014; he released her to work on January 20, 2014 although she continued receiving treatment and therapy after that date. On March 11, 2014, Petitioner returned to the emergency room because she had dropped a pan of pizza after her right arm became stiff and weak. She received more x-rays and was given a sling. Dr. Jones released her from his care a few days after that. Petitioner sought care from nurse practitioner Rebecca Carter in April and May 2014 due to persistent symptoms. Ms. Carter took Petitioner off work from April 2, 2014 to May 15, 2014. Following a right shoulder MRI, Ms. Carter released Petitioner to work without restrictions on May 16, 2014.

On cross-examination, Petitioner admitted that neither the Co-Op Building nor the adjacent parking lot in which she fell were owned by the school district; they were owned by the Co-Op. Other educational districts in addition to Respondent School District used the Co-Op Building: R.A.A.C.; S.A.L.T., and IMPACT. Students from school districts in Clifton, Herscher, St. Anne and Momence also used the Co-Op Building. Petitioner admitted: she did not know who maintained the parking lot; Respondent did not direct its employees to park in the lot, and other workers not employed by Respondent also parked in the lot.

While working at her head cook job, Petitioner had no need to go to her car in the lot at any time before her shift ended. Immediately prior to her fall, Petitioner was planning to drive to the LCC Building to begin working her second job. Respondent did not require her to go to the LCC Building for any reason. Although she typically started her second job at 2:00 pm, she could stop at home or run errands in between the jobs.

Cathy Breeck, Petitioner's supervisor and Director of Food Service for the Kankakee School District, testified on behalf of Respondent that the parking lot in which Petitioner fell was neither owned nor maintained by Respondent, but rather, it was owned and maintained by the Cooperative. Although Petitioner parked in the same space in the lot every day, Respondent did not require her to do so. Petitioner's duties in her Fruit and Vegetable Program job were different than her head cook duties. At a meeting for employees in the Fruit and Vegetable Program, they were made aware that that job was separate from their primary jobs and were reminded to "clock out" of their primary jobs when their shifts ended and to "clock in" at their Fruit and Vegetable Program jobs.

Records from St. Mary's Hospital show that on January 14, 2014 Petitioner was treated for a right wrist sprain, right elbow sprain and right knee/hip contusion. Petitioner saw Dr. Eddie Jones two days later; he considered her disability status to be temporary and her prognosis, good. He released her to her regular work with no restrictions on January 20, 2014. ATI Physical therapy records showed Petitioner completed 11 therapy sessions by March 13, 2014, and was discharged having met all short term and long term goals. A right shoulder MRI taken at that time showed no significant tear; only mild supraspinatus tendinopathy.

The Arbitrator found Petitioner did prove a compensable accident even though she had "clocked out" of her head cook job, because her accident occurred in a parking lot provided by Respondent. Citing *Vill v. Industrial Comm'n, 365 Ill.App.3d 906 (1st Dist., 2006),* the Arbitrator noted the general rule that injuries from slip and falls off an employer's premises while traveling to or from work are ordinarily not compensable under the Workers' Compensation Act. However, the Arbitrator found that the facts herein placed Petitioner's claim within the "parking lot exception" to the general rule noted in *Vill*: such injuries are compensable if the fall occurred in a lot provided by and under the control of the employer. In those circumstances, the rationale for awarding workers' compensation benefits is that the "employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey, 345 Ill.App.3d at 1038; Suter v. Ill. Workers' Comp. Comm'n, 2013 IL App (4th) 130049WC (4th Dist., 2013).*

The Commission finds Petitioner failed to prove Respondent provided or controlled the lot where she fell, both of which were required in order for the parking lot exception to apply.

There is no evidentiary basis for the arbitrator's conclusions that, "The parking lot in which Petitioner was injured constitutes a part of Respondent's premises," or that the lot, "was implicitly provided by Respondent for Petitioner and other employees to use…" No documentary evidence or testimony established that Respondent *provided* the subject parking lot to its employees. To the contrary, both Petitioner and witness Breeck testified the lot was provided by the Co-Op for use by employees of multiple employers in addition to Respondent.

None of the "facts" cited by the Arbitrator as proof that Respondent provided the lot establish that it did. In particular, the Arbitrator's finding that the general public was not allowed to park in the subject parking lot is unsupported by evidence. Petitioner's testimony that, as far as she knew, no one from the general public parked in the area of the lot where she and her co-workers did, is, without more, insufficient proof that the public was prohibited from parking in the lot. Petitioner offered no other evidence which proved Respondent provided the lot.

The Commission finds nothing in the record which proved that Respondent *controlled* the parking lot. Petitioner's testimony that she never saw the general public park in the lot is similarly insufficient to establish control of the lot by Respondent. The only evidence tending to show who controlled the lot was the testimony of Ms. Breeck – and she testified that the lot was maintained by the Co-Op, not by Respondent. Petitioner admitted she did not know who controlled the lot when she was asked, and she offered no other evidence to refute Ms. Breeck's credible testimony.

While the Commission acknowledges that a Petitioner may be able to prove who controlled a parking lot by establishing facts other than showing who maintained it, no such facts are present here. The evidence supports a conclusion that the Co-Op, not Respondent, controlled the lot where Petitioner fell.

The Commission decision in *Jenkins-Kress v. Gateway Health Care, Ltd. 10 WC 14080, 13 IWCC 110; 2013 Ill. Wrk. Com. LEXIS 70 (January 31, 2013)* is distinguishable from the facts in this case. In *Jenkins-Kress*, the Petitioner testified she was told to park in one of two parking lots, and there was a written policy instructing employees where to park hanging on a window in the building. Here, Petitioner admitted she was not directed by Respondent to park where she did. No other facts demonstrate Respondent provided or controlled the lot. The Commission finds Petitioner failed to prove the parking lot exception applies to the facts in this case.

The Commission has also considered theories of recovery in addition to the *Vill* parking lot exception, and finds none support an award in favor of Petitioner.

In *Vill*, a second exception was noted to the general rule of non-compensability for injuries off the employer's premises while traveling to or from work, but it also does not apply here. The second exception permits recovery when an employee is injured at a place where he or she was required to be in the performance of his or her duties *and* was exposed to a risk to a greater degree than the general public.

At the time of her fall, Petitioner was not required to be in the parking lot to perform any duties, and she was not exposed to a risk to a greater degree than the general public. Her head cook duties required her presence in the Co-Op Building, not in the parking lot. She had not been directed to park in the lot in question for any reason. Petitioner's risk of walking through an icy parking lot was not incidental to her employment. A risk is incidental to employment where it belongs to or is connected with what an employee must do in fulfilling their duties. *Steak 'n Shake v. Illinois Workers' Compensation Commission, 2016 IL App. (3d) 150500WC; 67 N.E.3d 571 (3rd Dist., 2016).*

The facts in this case are similar to those in *Wal-Mart Stores, Inc. v. Industrial Commission, 326 Ill.App.3d 438 (4th Dist., 2001).* There, after leaving work, the Petitioner slipped and fell in an icy parking lot which, as in this case, was not restricted to employees only. The court found that Petitioner's injuries not compensable, and that Petitioner's accident to not be the result of a hazard arising out of her employment or a risk greater than faced by the general public.

Nor was Petitioner herein a traveling employee at the time of her fall. She had clocked out of her head cook job, which did not require her to travel. She was not in the furtherance of any job duties at Respondent when she fell. She was not bringing anything from her head cook job to her second job. She was not directed by her employer to go to her second job, or to take a particular route. She was not paid for her time or her mileage after leaving her head cook job. The Commission finds Petitioner did not prove her accident arose out of or in the course of her employment by Respondent. It is unnecessary to address the remaining issues.

IT IS THEREFORE ORDERED BY THE COMMISSION that the January 15, 2016 Decision of the Arbitrator in this matter is hereby vacated and all benefits to Petitioner are denied.

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

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

DATED: AUG 1 8 2017

o-06/21/17
jdl/mcp
68

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

BROOKS, HELEN
Employee/Petitioner

Case# **14WC004973**

KANKAKEE SCHOOL DISTRICT 111
Employer/Respondent

17IWCC0518

On 1/15/2016, 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 0.47% 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:

2333 WOODRUFF JOHNSON & PALERMO
JAY JOHNSON
4234 MERIDIAN PKWY SUITE 134
AURORA, IL 60504

0075 POWER & CRONIN LTD
JOHN FASSOLA
900 COMMERCE DR SUITE 300
OAKBROOK, IL 60523

STATE OF ILLINOIS)
)SS.
COUNTY OF KANKAKEE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Helen Brooks
Employee/Petitioner

v.

Kankakee School District 111
Employer/Respondent

Case # 14 WC 4973

Consolidated cases: N/A

17IWCC0518

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Barbara N. Flores**, Arbitrator of the Commission, in the city of **Kankakee**, on **November 16, 2015**. After reviewing all of the evidence presented, the undersigned Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

A. ☐ Was Respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?
B. ☐ Was there an employee-employer relationship?
C. ☒ Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent?
D. ☐ What was the date of the accident?
E. ☐ Was timely notice of the accident given to Respondent?
F. ☒ Is Petitioner's current condition of ill-being causally related to the injury?
G. ☐ What were Petitioner's earnings?
H. ☐ What was Petitioner's age at the time of the accident?
I. ☐ What was Petitioner's marital status at the time of the accident?
J. ☒ 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 14, 2014, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* sustain an accident that arose out of and in the course of employment 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 $23,920.00; the average weekly wage was $460.00.

On the date of accident, Petitioner was 47 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 $3,643.60 under Section 8(j) of the Act. *See* AX1.

ORDER

As explained in the Arbitration Decision Addendum, the Arbitrator finds that Petitioner has established that she sustained a compensable accident at work as well as causal connection between her current condition of ill-being and her injury at work.

Temporary Total Disability

Respondent shall pay Petitioner temporary total disability benefits of $306.67/week for 7 & 1/7th weeks, commencing January 15, 2014 through January 19, 2014 and April 2, 2014 through May 16, 2014, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the temporary total disability benefits that have accrued from January 14, 2014 through November 16, 2015, and shall pay the remainder of the award, if any, in weekly payments.

Medical Benefits

Respondent shall pay reasonable and necessary medical services totaling $19,002.03 as reflected in Petitioner's Exhibits that remain unpaid 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 $3,643.60 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

Respondent shall pay Petitioner permanent partial disability benefits of $276.00/week for 6.45 weeks, because the injuries sustained caused the 3% loss of use of the right leg/hip, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $276.00/week for 5.06 weeks, because the injuries sustained caused the 2% loss of use of the right arm/elbow, as provided in Section 8(e) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $276.00/week for 5 weeks, because the injuries sustained caused the 1% loss of use of the right shoulder pursuant to §8(d)2 of the Act.

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

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

Signature of Arbitrator

January 12, 2016
Date

ICArbDec p. 3

JAN 15 2016

17IWCC0518

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION *ADDENDUM*

Helen Brooks
Employee/Petitioner

v.

Kankakee School District 111
Employer/Respondent

Case # **14** WC **4973**

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 a period of temporary total disability benefits commencing on commencing January 15, 2014 through January 19, 2014 and April 2, 2014 through May 16, 2014, and the nature and extent of the injury. Arbitrator's Exhibit[1] ("AX") 1. The parties have stipulated to all other issues. AX1.

Background

Petitioner testified that she started working for Respondent in June of 2000 as a Cafeteria Supervisor and was ultimately promoted to Head Cook II. Her duties included preparing and cooking food and making associated purchase orders. She worked in the co-op building where food was prepared for four schools from 7:00 a.m. to 1:30 p.m. and she always reported to this building for her work as a Head Cook II. Petitioner testified that there are other educational entities (i.e., "RAAC," "SALT" and "IMPACT") that used the co-op building. She worked in the co-op building with Respondent's employees and employees of other entities. Petitioner worked at the co-op Monday through Friday.

Petitioner also worked at the Lincoln Cultural Center (LCC), located in a different Kankakee School District building preparing fruits and vegetables. Petitioner testified that she went to the LCC building to do work under the fruit and vegetable program, which was different from her Head Cook II position at the co-op building. Petitioner explained that this was a special program to which Respondent's employees could apply and that the program ended last year.

Petitioner acknowledged that she was not required to do the work for the fruit and vegetable program under her Head Cook II position, but chose to work in that separate program. She also acknowledged that she did not take any items with her from her Head Cook II work at the co-op building when she went to the LCC building. Petitioner signed separate time sheets for both jobs and testified that she was not required by Respondent to go directly from the co-op building to the LCC building to perform fruit and vegetable program work. However, Petitioner also testified that her paycheck showed a separate line on the check for payment of her co-op and LCC building work. Both jobs were paid by the Kankakee School District from different funding sources.

Petitioner testified that she worked at LCC beginning at 2:00 p.m. and worked varied hours each day from Monday through Thursday until her work at LCC was done. Petitioner testified that LCC is located approximately a 10-15 minute drive from the co-op building. Petitioner drove between the two buildings and

[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. Joint exhibits are denominated with "JX."

parked in the employee parking lot by the co-op building. Photographs of the parking lot in which Petitioner parked in front of the co-op building, as well as the side entrance which she used to enter the building, were offered into evidence. JX1a & JX1b; RX1. The photographs show a sign that says "Iroquois-Kankakee SALT Regional Alternative Attendance Center[.]" JX1a; RX1.

To Petitioner's knowledge, the parking lot in which she was injured is not owned by the school district and it is used by other educational institutions including "RAAC," "SALT" and "IMPACT" from District 111 and other school districts. Petitioner explained that she used the sidewalk to go from her car to the side entrance of the co-op building. See JX1a-JX1b; RX1. Petitioner testified that there was no way for her to get from her vehicle to the co-op door other than through the icy parking lot on the date of accident. She could not have performed her job anywhere other than in the co-op building.

Petitioner testified that she parked in the same spot every day, and explained that all of the employees parked in the same spots every day. She acknowledged that she was not directed to park in the particular parking spot in which she did by Respondent. Petitioner also testified that the general public could not park in this parking lot and students had separate entrances to enter the co-op building from the food service door entrance that she used.

January 14, 2014

On January 14, 2014, Petitioner testified that she parked her car in the usual spot. She explained that she could not see the sidewalk because it was covered in snow plowed up against the building. Petitioner testified that the parking lot was icy, but she made it into the co-op building that morning. At the end of her day, she locked up the co-op building and she slipped and fell as she was walking through the parking lot. Petitioner testified that she fell on her right side and hit her shoulder, wrist, elbow, hip, knee and ankle and felt pain. Petitioner testified that she slid herself to the car and pulled herself up by the door handle then went to the SALT building to get help.

Medical Treatment

On January 14, 2014, Petitioner then went to St. Mary's Hospital for emergency medical treatment. PX1. The hospital records document Petitioner's right-sided symptoms and reported history of fall in the parking lot at work. *Id.* At the time, x-rays could not exclude a shoulder separation and the emergency room physician placed Petitioner off of work. *Id.* Petitioner was referred to Dr. Jones at Orthopedic Associates of Kankakee. *Id.*

Petitioner first saw Dr. Jones on January 16, 2014. PX2. Dr. Jones noted Petitioner's history of accident and her reported pain in the right elbow, right wrist, right knee, right ankle, right thigh and right hip. *Id.* He diagnosed right knee, ankle, shoulder and wrist pain. *Id.* He also released her to return to full duty work effective January 20, 2014. *Id.* On cross examination, Petitioner acknowledged that she did not report right elbow pain at this time. She also testified that she returned to her regular job duties until April 2, 2014.

Petitioner followed up with Dr. Jones on February 6, 2014. PX2. Dr. Jones noted that he'd recently seen Petitioner to treat extensor tendinitis of the right wrist and Petitioner's report that she'd also injured her hip with continued pain which was worse when sitting down. *Id.* Dr. Jones diagnosed right knee, shoulder, ankle and wrist pain as well as hip abductor tendonitis and he ordered three weeks of physical therapy. *Id.*

Thereafter, Petitioner began a course of physical therapy at ATI Physical Therapy on February 14, 2014. PX3. The therapy focused on the right hip. *Id.* Petitioner testified that physical therapy focused on the hip and shoulder and that the therapy went well—she had some improvement. The physical therapy records reflect that Petitioner remained in therapy until March 7, 2014. *Id.*

Petitioner then returned to the emergency room at St. Mary's on March 11, 2014. PX1. Petitioner testified that she was at work and her right elbow and arm got stiff. Then she felt weakness and dropped a pan of pizza. The emergency room records reflect that Petitioner's main complaint was related to "[right] arm pain injury on 1/14/14." *Id.* The physician noted a positive Tinel's sign and a possible chip fracture in the right elbow. *Id.* Petitioner was diagnosed with right elbow pain and cubital tunnel syndrome on the right. *Id.*

Thereafter, Petitioner returned to Dr. Jones on March 13, 2014 at which time he released her from his care. PX2. Petitioner reported that her right his was doing well and Dr. Jones diagnosed resolved right hip pain, abductor tendonitis. *Id.* She remained released to full duty work. *Id.*

Petitioner testified that although she felt better at this time, she was not 100%. She continued to work although her right hip and right elbow continued to bother her. Consequently, she decided to seek additional medical treatment.

Petitioner then came under the care of a nurse practitioner, Rebecca Carter, N.P. (Ms. Carter), at Riverside Medical Center on April 2, 2014. PX4. Petitioner testified that she was still in a little pain at this time and that she reported the accident. Ms. Carter noted Petitioner's report of an accident at work on January 14, 2014 and aching pain to the entire right side. *Id.* She reported continued right hip, right knee, right elbow and right shoulder tenderness as well as numbness and tingling in her right fingers. *Id.* Ms. Carter recommended x-rays and a right shoulder MRI. *Id.* She also placed Petitioner off work and prescribed medication. *Id.* Petitioner testified she turned in the off work slip to Carol Goodridge at work.

Petitioner followed up with Ms. Carter on April 9, 2014. PX4. She reported that the pain medications helped control her pain somewhat, but Ms. Carter continued to restrict Petitioner from work. *Id.* She also continued to recommend a right shoulder MRI. *Id.*

Petitioner returned to Riverside Medical Center on April 16, 2014. PX4. She reported that she still had not undergone the MRI due to lack of insurance approval. *Id.* Ms. Carter continued to note Petitioner's right shoulder and elbow pain and she diagnosed cervical radiculopathy, right shoulder pain and right elbow pain. *Id.*

Petitioner ultimately underwent the recommended MRI on May 9, 2014. PX4. It revealed mild supraspinatus tendinopathy. *Id.* Petitioner testified that she did not follow up with Ms. Carter after discussing the MRI results of May 9, 2014 with her over the phone. She understood that Ms. Carter released her back to work effective May 16, 2014 and that no additional treatment was recommended. Petitioner testified that she has worked for Respondent since that time.

Cathy Breeck

Ms. Breeck testified that was employed by Respondent until her retirement on June 30, 2013 as the Food Service Director. Ms. Breeck explained that Petitioner called her to report that she fell at work on January 14, 2014 after 1:30 p.m. and described the area in which she fell. Ms. Breeck directed Petitioner to fill out an accident report.

Ms. Breeck also testified that the parking lot is owned and maintained by the co-op. Petitioner parked in the same spot every day. She also used the food entrance door along with one other employee. Ms. Breeck also testified about the relationship between the co-op building and SALT program. She explained that the SALT program is run by the regional office of education, which is not the same as the Kankakee School District, as well as the Kankakee School District. Employees of SALT are not employed by the Kankakee School District.

Ms. Breeck also testified that the Kankakee School District has a grant for a fresh fruit and vegetable program and the food is prepared at the LCC building. She explained that Kankakee School District employees could sign up to perform work for the fresh fruit and vegetable program twice per year if they so chose. Petitioner and other employees also worked this program. Ms. Breeck testified that employees working the fresh fruit and vegetable program only prepared packaged fruits and vegetables. Employees were required to clock in and clock out of each job. Ms. Breeck testified that Petitioner was not working as a Head Cook II in her role at the LCC for the fresh fruit and vegetable program. She also testified that Petitioner would only work the LCC program when there was need and she would sign in on a separate timesheet. Ms. Breeck testified that there was no requirement for Petitioner to go directly from the co-op building to the LCC building.

However, on cross examination Ms. Breeck testified that the when the fresh fruit and vegetable program started, employees were told that the work would start at 2:00 p.m. or earlier if the employees could come there earlier. Once per semester, a schedule was sent out and the individual employee would fill out the days they could work at the LCC building and employees had to stick to the schedule. Ms. Breeck testified that there were other food services programs at the LCC building, but those depended on available grants. Ms. Breeck supervised Petitioner at both the co-op and LCC.

Additional Information

Petitioner testified that prior to her accident at work, she had no injury to the right hip, right elbow, right wrist, right knee or right shoulder. She also testified that she has not had any injury to these body parts after her accident.

Regarding her current condition, Petitioner testified that her right shoulder feels heavy sometimes and stiff every couple of months. She testified that she puts a heating pad on the right shoulder and takes Naproxen as prescribed by Nurse Carter. Regarding her right hip, Petitioner testified that if she sits or lays down too long she feels stiffness every six months or so. These symptoms are improved with walking. Regarding her right elbow, Petitioner testified that she takes pain medication if she feels pain. Petitioner understands that there is a chip in her right elbow and that she feels pain there two-to-three times per month. Regarding her right knee, Petitioner testified that the knee is fine. Petitioner testified that she experiences the most problems with her hip.

ISSUES AND CONCLUSIONS

The Arbitrator hereby incorporates by reference the Findings of Fact delineated above and the Arbitrator's and parties' exhibits are made a part of the Commission's file. After reviewing the evidence and due deliberation, the Arbitrator finds on the issues presented at trial as follows:

In support of the Arbitrator's decision relating to Issues (C) and (D), whether an accident occurred that arose out of and in the course of Petitioner's employment by Respondent and the date of the accident, the Arbitrator finds the following:

The parties' dispute regarding accident stems primarily from three theories of compensability. First, whether Petitioner's injury is compensable under either an increased risk analysis, second whether the injury is compensable under a "parking lot exception" analysis and finally whether the injury is compensable under a traveling employee analysis. In light of the facts adduced at trial, the Arbitrator finds that Petitioner has established that she sustained a compensable injury at work under the parking lot exception theory of recovery.

An employee's injury is compensable under the Act only if it "arises out of" and occurs "in the course of" the employment. 820 ILCS 305/2 (LEXIS 2011). A claimant must prove both elements were present. *University of Illinois v. Industrial Comm'n*, 365 Ill. App. 3d 906, 910 (1st Dist. 2006); *Sisbro, Inc. v. Industrial Comm'n*, 207 Ill. 2d 193, 203-04 (2003). There is an entire line of cases addressing employee injuries sustained in parking lots, the substance of which is summarized in *Suter v. Ill. Workers' Comp. Comm'n*:

> "When an employee slips and falls, or is otherwise injured, at a point off of the employer's premises while traveling to or from work, her injuries are ordinarily not compensable under the Act." *Vill v. Industrial Comm'n*, 351 Ill. App. 3d 798, 803, 814 N.E.2d 917, 921, 286 Ill. Dec. 691 (2004). Under such circumstances, the accident occurs outside "the course of" the employment. *Northwestern University v. Industrial Comm'n*, 409 Ill. 216, 221, 99 N.E.2d 18, 21 (1951).
>
> However, Illinois courts have recognized two exceptions to this "general premises rule." *Mores-Harvey v. Industrial Comm'n*, 345 Ill. App. 3d 1034, 1038, 804 N.E.2d 1086, 1090, 281 Ill. Dec. 791 (2004). First, "recovery has been permitted for off-premises injuries when 'the employee's presence at the place where the accident occurred was required in the performance of his duties and the employee is exposed to a risk common to the general public to a greater degree than other persons.'" *Id.* (quoting [*Illinois Bell Tel. Co. v. Industrial Comm'n*, 131 Ill. 2d 478, 484, 546 N.E.2d 603, 605 (1989)]).
>
> Second, there is a "parking lot exception" where courts have allowed recovery when the employee is injured in a parking lot provided by and under the control of the employer. *Vill*, 351 Ill. App. 3d at 803, 814 N.E.2d at 922. This exception applies in circumstances where the employee's injury is caused by some hazardous condition in the parking lot. *Id.*

Suter v. Ill. Workers' Comp. Comm'n, 2013 IL App (4th) 130049WC, P19-P22, 376 Ill. Dec. 261, 266-267 (4th Dist. 2013). Similar to the facts in *Suter*, the evidence presented here clearly requires an analysis under the parking lot exception case law. Aside from the traveling employee theory of recovery, the parties' dispute centers on whether Respondent's premises extends to the parking lot in which Petitioner was injured.

> The rationale for awarding workers' compensation benefits when an employee is injured because of the conditions of an employer-provided parking lot is that the "employer-provided parking lot is considered part of the employer's premises." *Mores-Harvey*, 345 Ill. App. 3d at 1038, 804 N.E.2d at 1090. In applying the parking lot exception, Illinois courts have held that so long as the employer has provided a

> parking lot for use by its employees, the fact that the employer does not own the lot is immaterial. *C. Iber & Sons, Inc. v. Industrial Comm'n*, 81 Ill. 2d 130, 135, 407 N.E.2d 39, 42, 40 Ill. Dec. 808 (1980). In addition, once the parking lot is considered part of the employer's premises, any injury on the parking lot is compensable if it would be compensable on the employer's main premises. *Mores-Harvey*, 345 Ill. App. 3d at 1038, 804 N.E.2d at 1090-91.

Suter, 2013 IL App (4th) 130049WC at P23, 376 Ill. Dec. at 266-267. Similar to the circumstances in *Suter*, the relevant facts in this case are established either through Petitioner's testimony, which is corroborated by the testimony of Ms. Breeck, or wholly uncontroverted evidence. The following facts are undisputed.

Petitioner worked as a Head Cook II for Respondent. She could only perform her work in the co-op building. Petitioner had been employed by Respondent for years before her injury during which time she parked in a parking lot located directly adjacent to the co-op building. Petitioner parked in the same parking space in this parking lot as did other employees who habitually parked in the same parking spaces every day.

Petitioner generally used a sidewalk to walk from her car to the food service entrance of the co-op building. However, on the date of accident snow was plowed up against the side of the co-op building over the sidewalk so Petitioner walked through the parking lot to reach the food service entrance. Petitioner successfully walked through the parking lot in the morning, worked throughout the day and completed her work as a Head Cook II on January 14, 2014. She then locked up the co-op building and exited toward her car through the parking lot because the sidewalk remained covered in snow. While walking through the parking lot to her car Petitioner slipped and fell on ice causing injury to the right side of her body.

No one directed Petitioner to park in the particular space or in the parking lot in which she parked on the date of accident. The general public and students did not park in the parking lot. Neither Petitioner nor Ms. Breeck knew who owned or maintained the parking lot.

Whether Respondent owned the parking lot in which Petitioner fell is of no consequence in determining whether her injury is compensable. See *Suter*, 2013 IL App (4th) 130049WC at P23-P25; see *C. Iber & Sons, Inc. v. Industrial Comm'n*, 81 Ill. 2d 130, 135 (1980); see *De Hoyos v. Industrial Comm'n*, 26 Ill. 2d 110, 113-114 (1962). The inquiry requires a determination of whether Respondent provided the parking lot to Petitioner who was injured thereon due to a hazardous condition. *Suter*, 2013 IL App (4th) 130049WC at P25 (citing *De Hoyos*, 26 Ill. 2d at 114); *Mores-Harvey v. Indus. Comm'n*, 345 Ill. App. 3d 1034, 1038 (3rd Dist. 2004). "If this is the case, then the lot constitutes part of the employer's premises," and "[t]he presence of a hazardous condition on the employer's premises that causes a claimant's injury supports the finding of a compensable claim." *Mores-Harvey*, 345 Ill. App. 3d at 1040.

Petitioner was walking from the co-op building to a parking lot provided by Respondent for her and other employees to use. The general public was not allowed into the parking lot. Petitioner was injured when she slipped and fell on ice walking through the parking lot because the sidewalk she normally used to reach the co-op building was covered with plowed snow. The parking lot in which Petitioner was injured constitutes a part of Respondent's premises, was implicitly provided by Respondent for Petitioner and other employees to use and it was in a hazardous condition given the ice on which Petitioner slipped and fell. Based on all of the foregoing, the Arbitrator finds that Petitioner has established that she sustained a compensable accident at work on January 14, 2014[2].

[2] Given that Petitioner established that she sustained a compensable accident under the parking lot exception analysis, no conclusion regarding the alternative theories is required.

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:

The Arbitrator finds that Petitioner's current condition of ill-being is causally related to the injury sustained at work on January 14, 2014. Petitioner had no injury or pre-existing condition in any of the body parts affected on the right side of the body until after her accident at work. Her testimony is consistent with the medical records submitted into evidence, and she contemporaneously reported symptoms on the right side of the body in the in the right shoulder, arm, wrist, hip, knee and ankle immediately after her accident throughout a short period of medical treatment lasting four months. No medical opinion was offered into evidence to controvert Petitioner's reported onset of symptoms after her January 14, 2014 accident at work throughout this period of treatment. Based on all of the foregoing, the Arbitrator finds that Petitioner's claimed current condition of ill-being is related to the injury sustained 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, 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 more fully above, the Arbitrator finds that Petitioner has established that she sustained a compensable accident at work affecting the right side of her body as well as a causal connection between her current condition of ill-being and her injury at work. In addition, the medical bills incurred by Petitioner are related to treatment of pain and symptoms manifesting in the right shoulder, arm, wrist, hip, knee and ankle only after her accident to alleviate her of the effects of her injury at work. Thus, the Arbitrator finds that the medical bills submitted into evidence that remain unpaid shall 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:

In light of the accident and causal connection analyses explained above, the Arbitrator addresses Petitioner's claim that she is entitled to temporary total disability benefits for the disputed period beginning January 15, 2014 through January 19, 2014 and April 2, 2014 through May 16, 2014.

"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).

As explained above, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to her

injury at work. Moreover, Petitioner was placed off work by treating physicians or a nurse practitioner for symptoms in the affected body parts after her injury at work. No contrary medical evidence was submitted at trial.

Based on all of the foregoing, the Arbitrator finds that Petitioner is entitled to temporary total disability benefits as claimed from January 15, 2014 through January 19, 2014 and April 2, 2014 through May 16, 2014.

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.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report was offered into evidence. As a result, the Arbitrator assigns no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that Petitioner was employed as a full time Head Cook II. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 47 years old at the time of the accident. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that Petitioner was released back to full duty work and has continued to work as a Head Cook II for Respondent earning the same pay. As a result, the Arbitrator gives significant weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator finds that Petitioner's testimony was credible because it was corroborated by the medical records as well as the testimony of Ms. Breeck. Petitioner credibly testified about her conservative medical treatment and ongoing symptoms, which waxed and waned, over a short four month period of time. The medical records also reflect that Petitioner underwent conservative medical treatment including several weeks of physical therapy focused primarily on the right hip as well as other treatment including bracing of the right elbow and right knee and prescribed pain medication to manage her right-sided symptoms. Petitioner was initially released back to full duty work days after her accident and then placed off work for a short period of time after a flare-up in right elbow and right shoulder symptoms prompted emergency room care and later follow up at Riverside Medical Center. Petitioner credibly testified about her limited ongoing symptoms in the right hip, right shoulder and right elbow. As a result, the Arbitrator gives significant weight to this factor.

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 has established permanent partial disability to the extent of 3% loss of use of the right leg/hip and 2% loss of use of the right arm/elbow pursuant to §8(e) of the Act and 1% loss of use of the right shoulder pursuant to §8(d)2 of the Act.

STATE OF ILLINOIS)	☐ Affirm and adopt (no changes)
)	☐ Affirm with changes
)	☒ Reverse: causation
COUNTY OF DUPAGE)	☐ Modify

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Robert Watson,
Petitioner,

vs.

NO: 14 WC 28608

17IWCC0519

Wal-Mart Associates, Inc.,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) has been filed by Respondent herein and notice given to all parties. The Commission, after considering issues including causal connection, temporary total disability, medical expenses, and prospective medical, and being advised of the facts and law, hereby reverses the February 8, 2016 decision of Arbitrator Granada, as stated below. The Arbitrator's decision is attached hereto.

The Arbitrator found that Petitioner proved a compensable injury in the form of an aggravation, sustained on July 22, 2014, to the preexisting arthritis in his knees. The Arbitrator awarded total temporary disability benefits, medical expenses, and prospective treatment, including bilateral total knee replacement as recommended by Dr. Steven Sclamberg. The Commission, after reviewing the entire record, views the evidence differently from the Arbitrator. In particular, the Commission finds that Petitioner has failed to prove that his condition of ill-being was caused by the asserted workplace accident. Accordingly, the Commission reverses the Arbitrator's decision and vacates all awards of benefits.

FACTUAL BACKGROUND

Petitioner, Robert Watson, 63 years old, was employed as a maintenance worker by Respondent for 13 years as of July 22, 2014. In the year prior to the date of asserted accident, he moved from a full-time position to part-time, working three days per week. On occasion, he would be directed by his supervisor to collect carts in the parking lot at the end of the day. (Tr. 9-10, 24-25). According to his testimony, on the evening of Tuesday, July 22, 2014, he hurt his knees while pushing 4 to 6 carts. He was attempting to maneuver the carts to avoid hitting a parked car when he felt a painful pulling or stretching in the back of both knees. The right knee hurt worse than the left. He attested that, while past episodes of knee pain would subside with Aleve and rest, this time the pain persisted. (Tr. 11-13).

On July 29, 2014, Petitioner sought attention from his primary care physician, Dr. Roman Dreyer. Dr. Dreyer's notes indicated that Petitioner "has pain bilateral knees, posterior area;" that the pain was "ongoing x 4 months;" and the pain was "possibly triggered by pushing carts at work." (PX 1). No prior treatment was noted. Bilateral knee x-rays showed moderate bilateral medial and patellofemoral compartment degenerative changes, worse on the right. (PX 1). About a week later, Petitioner presented to a chiropractor, who placed Petitioner off-work, prescribed physical therapy, and ordered MRIs of his knees. (PX 3). The right knee MRI, done on August 15, 2014, revealed extensive degenerative disease primarily in the medial compartment; Grade IV chondromalacia (complete cartilage loss) at the patella; and Grade III meniscus tear. (PX 6). A left knee MRI done a month later yielded the same findings of degenerative disease, chondromalacia, and meniscus tear in that knee as well. (PX 6).

On August 20, 2014, Petitioner was evaluated by Dr. Arpan Patel of Chicago Pain & Orthopedic Institute. Petitioner was prescribed pain medications. On September 10, 2014, Petitioner followed up with Dr. Patel's colleague, Dr. Christos Giannoulias, who administered an intraarticular injection in the right knee. Dr. Giannoulias, noting the severity of Petitioner's arthritis, believed that an arthroscopy would not be of benefit. On October 8, 2014, Dr. Giannoulias referred Petitioner to orthopedic surgeon Dr. Steven Sclamberg for consultation regarding knee replacement. (PX 4).

On November 14, 2014, Petitioner presented to Dr. Sclamberg. Contrary to what he told his primary care physician, Petitioner told Dr. Sclamberg that he did not have any prior problems or prior pain in his knees. (PX 5 at 7). After reviewing x-rays, Dr. Sclamberg's impression was that Petitioner had "fairly severe" tricompartmental osteoarthritis, right knee greater than the left. (PX 5 at 10). Dr. Sclamberg recommended staged bilateral total knee replacement. Petitioner followed up with Dr. Sclamberg on four more occasions (December 1, 2014; February 6, 2015; April 24, 2015 and August 17, 2015). At each of these visits, the treatment plan for a total knee replacement remained the same and Petitioner was kept off-work.

17IWCC0519

MEDICAL TESTIMONY

Dr. David Garelick, Section 12 examiner

Petitioner was examined at Respondent's request by orthopedic surgeon Dr. David Garelick on October 10, 2014. Dr. Garelick authored a written report and testified via evidence deposition on January 7, 2015. (RX 1). His impression was that Petitioner had symptomatic osteoarthritis in both knees, right worse than left. He opined that this osteoarthritis was longstanding and had developed over years (that is, clearly the work incident did not cause this condition). He noted that the medial meniscal tears in both knees were of the "extruded" type, which is consistent with chronic degenerative tearing as opposed to acute tearing. (RX 1 at11-12).

Regarding whether the workplace incident, as described, "aggravated" the preexisting condition or otherwise represented an event that caused Petitioner to be disabled from work and to need the subsequent treatment, Dr. Garelick opined that it did not. Dr. Garelick pointed out that Petitioner was already symptomatic before that date, citing to Dr. Dreyer's July 29, 2014 note, wherein it is indicated that Petitioner's bilateral knee pain had been ongoing for four months. Further, Dr. Garelick felt that the alleged mechanism of injury whereby Petitioner hurt his knees through pushing shopping carts represented a "minimal" amount of force, and was not descriptive of an acute injury. In Dr. Garelick's opinion, getting hurt through such a trivial incident was "more consistent with a chronic, ongoing, and lingering condition." (RX 1 at 25-26).

Dr. Steven Sclamberg, Treating Physician

Dr. Sclamberg testified via evidence deposition on October 26, 2015. Dr. Sclamberg agreed that Petitioner's osteoarthritis was advanced and was not caused by his employment. (PX 5 at 20). However, Dr. Sclamberg believed that the workplace incident of July 22, 2014 represented an aggravation that caused Petitioner's preexisting condition to become symptomatic, and constituted a compensable injury under the Act.[1] (PX 5 at 13-14). Dr. Sclamberg based this opinion solely on the history Petitioner provided of having no symptoms prior to the date of accident. (PX5 at 20-21). Dr. Sclamberg had not reviewed Petitioner's prior treatment records -- including Dr. Dreyer's notes -- prior to forming this opinion. He testified that his causation opinion would change if records suggested Petitioner did in fact have prior knee pain. (PX 5 at 21-22).

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[1] Generally speaking, a preexisting condition does not prevent recovery under the Act if that condition was aggravated or accelerated by the claimant's employment. An exception to that rule is articulated in *County of Cook v. Industrial Commission*, 69 Ill.2d 10, 370 N.E.2d 520 (1977): "Where it is shown the employee's health has so deteriorated that any normal daily activity is an overexertion, or where it is shown that the activity engaged in presented risks no greater than those to which the general public is exposed, compensation will be denied." *Id.* at 18. The first of these exceptions has been phrased alternatively as "where the employee's health has so deteriorated that any normal, daily activity could have caused the injury[.]" *General Refractories v. Industrial Commission*, 255 Ill.App.3d 925 at 931 (1994).

17IWCC0519

DISCUSSION

There is no question that Petitioner's arthritis in both knees preexisted the workplace incident that is asserted to be the accident. The degree of degeneration was advanced by that time. Both Dr. Garelick and Dr. Sclamberg agree on this point. However, the two doctors disagreed as to whether the current condition of Petitioner's knees – insofar as that condition may warrant restriction from working and total knee replacement – arose from that workplace incident.

The Arbitrator cited the opinion of Dr. Sclamberg in his decision in favor of Petitioner. However, Dr. Sclamberg based his opinion solely on the history related to him by Petitioner, who told Dr. Sclamberg that he had no pain in his knees pre-dating the accident. As noted above, the evidence shows that this history is inaccurate. As noted above, a few days after the accident, Petitioner complained to his primary care physician of knee pain that had been ongoing for four months. Dr. Sclamberg testified that his opinion would change if medical records indicated that Petitioner had knee pain before the accident.

The Commission finds that Dr. Sclamberg's opinion is flawed and that Dr. Garelick's opinion is more persuasive. The Commission concludes that Petitioner's preexisting arthritis was symptomatic before the asserted date of accident, and that the asserted accident is not causally related to the current condition of ill-being in his knees. The evidence shows that the current condition of his knees reflects the natural progression of his already-advanced arthritis, and is not due to any compensable "aggravation."

IT IS THEREFORE ORDERED BY THE COMMISSION that the decision of the Arbitrator filed February 8, 2016, is hereby reversed as discussed above. Benefits 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 18 2017

Joshua D. Luskin

Charles J. DeVriendt

L. Elizabeth Coppoletti

o-06/21/17
jdl/ac
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ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF 19(b) ARBITRATOR DECISION

WATSON, ROBERT
Employee/Petitioner

Case# **14WC028608**

WAL-MART ASSOCIATES INC
Employer/Respondent

17IWCC0519

On 2/8/2016, 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 0.46% 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 & MACIARIELLO
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CHICAGO, IL 60602

0560 WIEDNER & McAULIFFE LTD
BROOKE TORRENGA
ONE N FRANKLIN ST SUITE 1900
CHICAGO, IL 60606

STATE OF ILLINOIS)
)SS.
COUNTY OF DU PAGE)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION
19(b)

Robert Watson
Employee/Petitioner

v.

Wal-Mart Associates, Inc.
Employer/Respondent

Case # 14 WC 028608

Consolidated cases: ___

17IWCC0519

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 **Wheaton**, on **January 26, 2016**. 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 treatment**

17IWCC0519

FINDINGS

On the date of accident. **July 22, 2014**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$18,494.87**; the average weekly wage was **$355.67**.

On the date of accident. Petitioner was **63** years of age, ***married*** with **0** dependent children.

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

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

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

ORDER

Respondent shall pay directly to Petitioner temporary disability benefits of **$253.00/week** for **77 weeks**, commencing **8/6/2014** through **1/26/2016**, as provided in Section 8(b) of the Act.

Respondent shall pay directly to Petitioner reasonable and necessary medical services of **$15,915.55**, subject to the fee schedule as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall authorize and pay for the surgeries and all incidental treatment thereto consistent with the current recommendations of Dr. Sclamberg.

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

2/4/16
Date

FEB 8 - 2016

17IWCC0519

FINDINGS OF FACT

This case involves a Petitioner who alleges he was injured while working for the Respondent on July 22, 2014, resulting in injuries to both legs. (See Arb. Exh. 1 & 2) Respondent is disputing Petitioner's claim based on the following issues: 1) accident, 2) causation, 3) medical expenses, 4) TTD, and 5) prospective medical care.

Petitioner testified that on July 22, 2014, he had been employed by Respondent for nearly 13 years. On the date in question, Petitioner was employed by Respondent in the maintenance department. That day, Petitioner was tasked with collecting shopping carts from the parking lot. Petitioner testified that his main job duties with the maintenance department involved cleaning up around the store, but from time to time he would collect shopping carts as well. He testified that he had collected several shopping carts stacked together and attempted to turn the stack of carts to the right. Petitioner further testified that the stack of carts got stuck and started to lift up rather than continue to move forward, and he felt a stretching behind both knees. Specifically, Petitioner testified that it felt like balloons were stretching behind his knees, and that the right was worse than the left because he was turning to his right.

Petitioner testified that he switched to part time work in 2013 and worked three days a week. Petitioner further testified that prior to July 22, 2014 he would occasionally have soreness in his legs that he attributed to his age, but would be resolved after his days off. Petitioner denied any medical treatment for knee pain prior to July 22, 2014. Following the incident of July 22, 2014, the pain did not resolve and Petitioner presented to his primary care physician, Dr. Dreyer, on July 29, 2014. Dr. Dreyer noted bilateral pain in the knees, triggered by pushing 4-6 carts at work. Dr. Dreyer noted that pain was ongoing for four months but did not note any prior treatment. Dr. Dreyer recommended x-ray imaging and a follow up in 6 months. (PX 1).

Petitioner testified that he reported the injury to "Dennis," a supervisor at work, following his evaluation by Dr. Dreyer, and was referred for a drug test. Petitioner presented to MedSpring Urgent Care on July 31, 2014 for an occupational health drug screen. Petitioner was also evaluated by Dr. Gillis for complaints of bilateral knee pain after pushing 5-6 shopping carts. Dr. Gillis noted a history of a pulling sensation at the time of the injury and Petitioner reported the right knee hurt more than the left. Dr. Gillis diagnosed Petitioner with a knee strain and advised that a course of therapy was likely needed. (PX 2).

Petitioner testified that he next presented to Dr. Bodem at Rehab Dynamix on August 6, 2014. Dr. Bodem recorded a history of pushing 5-6 shopping carts on July 22, 2014 and a "painful pulling sensation" when making a turn with the carts. Pain was noted in the posterior distal thighs near the knee. The right knee was noted to be worse than the left. Dr. Bodem recommended a course of 6 therapy visit and took Petitioner off work for 2 weeks. (PX 3).

Dr. Bodem referred Petitioner to Imaging Centers of America for an MRI of the right knee on August 15, 2014. The radiologist noted degenerative disease of the knee, predominantly in its medial compartment with small joint effusion. Also noted was grade IV chondromalacia at the patella, medial femoral condyle and medial tibial plateau. A small ganglion cyst was noted, as well as a complex grade III tear in the posterior horn and the body of the medial meniscus. (PX 6).

17IWCC0519

At an August 19, 2014 follow up visit, Dr. Bodem reviewed the MRI results and referred Petitioner to an orthopedist to evaluate the right knee and continued Petitioner off work for four weeks. Petitioner continued to treat for therapy with Rehab Dynamix through November 11, 2014 (PX 3).

On August 20, 2014, Petitioner presented to Chicago Pain & Orthopedic Institute for evaluation with Dr. Arpan Patel. Dr. Patel noted complaints of right knee pain and a history of onset after pushing and turning six or seven carts at work. Dr. Patel prescribed Mobic and Teracin cream for pain, as well as tramadol for severe breakthrough pain. Dr. Patel continued Petitioner off work and referred him for an orthopedic evaluation. (PX 4).

On September 10, 2014, Petitioner next followed up with Dr. Christos Giannoulias at Chicago Pain & Orthopedic with complaints of bilateral knee pain, right worse than left. Petitioner gave a history of trying to lift and turn shopping carts at work. Dr. Giannoulis diagnosed Petitioner with a meniscus tear and severe arthritis. Dr. Giannoulias did not believe that an arthroscopy would be of benefit due to the severity of the arthritis. An intraarticular injection was administered with instructions for a three to four week follow up. (PX 4).

On September 22, 2014, Petitioner presented to Imaging Centers of America on the referral of Dr. Bodem for an MRI of the left knee. The radiologist noted degenerative disease of the knee, predominantly in its medial compartment with joint effusion. Also noted was grade IV chondromalacia at weight bearing surface of the medial femoral condyle, posterior aspect of the lateral femoral condyle, femoral trochlea, and medial tibial plateau. A grade III horizontal tear in the posterior horn and the body of the medial meniscus was also noted. (PX 6).

Petitioner followed up with Dr. Giannoulias on October 8, 2014 with bilateral knee pain. Dr. Giannoulias repeated his recommendation that with the condition of Petitioner's knee, arthroscopic repair was not indicated. He referred Petitioner to Dr. Sclamberg for consultation and evaluation for a possible knee replacement. (PX 4).

On October 10, 2014, Petitioner presented for Respondent's Section 12 examination with Dr. David Garelick. In his report following the evaluation, Dr. Garelick noted that Petitioner arrived on time and participated fully. Dr. Garelick noted a history of bilateral knee pain after turning a stack of five or six grocery carts from the parking lot. After physical examination and review of the medical records, Dr. Garelick opined that there was no pathology in either knee that was causally related to the July 22, 2014 incident. His opinion was that at most, Petitioner experienced a temporary exacerbation of a pre-existing condition that resolved within six to twelve weeks. Dr. Garelick found Petitioner to be at maximum medical improvement as of the date of the Section 12 examination. (RX 1).

Petitioner presented for an initial evaluation with Dr. Sclamberg on November 14, 2014. Dr. Sclamberg noted complaints of bilateral knee pain with a history of pushing shopping carts and straining the knee while trying to turn them when they stopped moving. After physical examination and reviewing a history of therapy and injections, Dr. Sclamberg recommended a total right knee arthroplasty. Dr. Sclamberg opined that the injury aggravated the underlying condition. (PX 4). Petitioner followed up with Dr. Sclamberg on December 1, 2014; February 6, 2015; April 24, 2015; and August 17, 2015. At each of these follow up visits, the treatment plan for a total knee arthroplasty remained the same and Petitioner was kept off of work. At the April 24 office visit, Dr. Sclamberg injected the right knee with lidocaine. (PX 4).

The evidence deposition of Dr. David Garelick, Respondent's Section 12 examiner, was completed on January 7, 2015. Dr. Garelick testified that at the time of the examination he had not reviewed records from Dr. Giannoulias. Dr. Garelick's report also indicated he had not reviewed records from Dr. Bodem and Rehab Dynamix. During the Section 12 evaluation, Dr. Garelick testified that he performed a physical evaluation and noted Petitioner was limping, favoring his right leg. Dr. Garelick took X-rays on the date of his evaluation and reviewed the MRI studies of each knee. Dr. Garelick testified that the meniscus tears were "extruded...consistent with chronic degenerative tears as opposed to acute tearing, typically." Based on a record review and physical examination, Dr. Garelick testified that his impression was of symptomatic degenerative arthritis in both knees, right worse than left. When asked for his opinion on causal connection, Dr. Garelick testified that he "felt that it was a chronic problem that had been ongoing." Dr. Garelick further testified that no further treatment was needed as it related to the incident and that Petitioner is not temporarily disabled as a result of the incident. With respect to medical treatment, Dr. Garelick testified that an injection was appropriate, while chiropractic treatment was not. Dr. Garelick further testified on cross-examination that he did not know what area of the knee prior pain was in or the frequency of the pain. Dr. Garelick also testified that with an exacerbation of degenerative arthritis, a knee replacement would be reasonable if after an exacerbation the patient did not return to the pre-exacerbation baseline. (RX 1 at 30).

The evidence deposition of Petitioner's treating physician, Dr. Steven Sclamberg was completed on October 26, 2015. Dr. Sclamberg testified that after nine months of treatment, his diagnosis was osteoarthritis of both knees, end-stage, symptomatic more in the right knee. Dr. Sclamberg further testified that the work injury did not cause the osteoarthritis, but that it did aggravate or accelerate the osteoarthritis. It was Dr. Sclamberg's testimony that it is possible for a person to have severe osteoarthritic findings and be asymptomatic. Dr. Sclamberg testified that Petitioner required staged bilateral knee replacements. (PX 5).

Petitioner testified that his right knee remains painful and that he has not worked since July 22, 2014. He is limited in household chores. Petitioner further testified that despite his fear of surgery, he does want the procedures so that he can try to work again.

CONCLUSIONS OF LAW

1. With regard to the issue of accident, the Arbitrator finds that the Petitioner has met his burden of proof. This finding is supported by the Petitioner's unrebutted testimony and the medical records. Petitioner credibly testified that he felt pain in his knees, more so in his right knee on July 22, 2014, as he was attempting to push a number of shopping carts. There was no evidence presented to the contrary by Respondent. Accordingly, the Arbitrator concludes that the Petitioner sustained an accident while working for the Respondent on July 22, 2014.

2. Regarding the issue of causation, the Arbitrator finds that the Petitioner has met his burden of proof. In support of this finding, the Arbitrator relies on the Petitioner's credible testimony and the medical evidence. This is the primary issue in dispute, upon which the Respondent relies on the opinion of its IME, Dr. Garelick to support its denial of this claim. Dr. Garelick relies on a medical report from one of Petitioner's treating physicians, Dr. Dreyer, who indicated that the Petitioner had been complaining of knee pain for four months before the alleged accident date. Dr. Garelick further opined that the Petitioner's incident of July 22, 2014 only presented a temporary aggravation of the Petitioner's pre-exisitng arthritis in his knees. On the other hand, Petitioner's treating physician, Dr. Sclamberg believed

17IWCC0519

that the Petitioner's incident on July 22, 2014 was an aggravation of the Petitioner's pre-existing osteoarthritis. Petitioner himself admitted that prior to the alleged accident date, he would experience soreness in his legs that would go away by the next day. However, he did not undergo any medical treatment for his knees prior to the alleged date of accident. Given the Petitioner's credible presentation at trial, the fact that Dr. Garelick did not review all of the Petitioner's treating medical records, and the fact that there is no evidence of Petitioner receiving medical treatment for his knees prior to the alleged accident date - the Arbitrator gives more weight to the opinions of Dr. Sclamberg. The evidence clearly shows that the July 22, 2014 incident was not a temporary aggravation of Petitioner's osteoarthritis, as Dr. Garelick described, because the Petitioner's condition has clearly progressed to the point where knee replacement surgery has been recommended by all his treating physicians. As such, the Arbitrator concludes that the Petitioner's current condition of ill-being in his knees are causally related to his July 22, 2014 work accident.

3. Based on the Arbitrator's findings with regard to the issues of accident and causation, the Arbitrator finds that the Petitioner's medical expenses related to treatment of his bi-lateral knee conditions were both reasonable and necessary in treating his work-related conditions. Accordingly, the Arbitrator awards the following expenses to the Petitioner subject to the fee schedule in accordance with Sections 8(a) and 8.2 of the Act:

$435.83 – Dreyer Medical Clinic
$10,471.32 – Rehab Dynamix
$1,658.40 - Chicago Pain & Orthopedic Institute
$3,350.00 - Imaging Centers of America

$15,915.55 – TOTAL

Respondent shall receive a credit for any of these expenses it may have already paid, either through workers compensation or through group insurance.

4. Based on the Arbitrator's findings with respect to the issues of accident and causation, the Arbitrator further finds that Petitioner's request for the prospective medical care as recommended by his treating physician Dr. Sclamberg, is reasonable, related and necessary in the treatment of Petitioner's work-related knee conditions. This would include the recommendation for total knee replacement surgery. Accordingly, the Respondent shall authorize and pay for additional reasonable and necessary treatment for Petitioner consistent with the current recommendations of Dr. Sclamberg including bilateral staged arthroplasty for the knees and any other related medical services.

5. With regard to the issue of TTD, the Arbitrator finds that the Petitioner has met his burden of proof. This finding is based on the Arbitrator's findings regarding accident and causation. Petitioner is entitled to temporary total disability benefits totaling $19,481.00 for the period of 77 weeks beginning August 6, 2014 through the trial date January 26, 2016. The Arbitrator notes that a physician did not place Petitioner off of work until Dr. Bodem's August 6, 2014 evaluation, and that the Petitioner has not been released to return to work as of the date of this hearing.

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 KANKAKEE	)	☒ Reverse Causal Connection	☐ Second Injury Fund (§8(e)18) ☐ PTD/Fatal denied
		☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Juan Carlos Gallardo,
Petitioner,

v.

NO: 13 WC 01782

17IWCC0520

Tyson 4T's Management,
Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review under §19(b) having been filed by Respondent and Petitioner appealing the decision of Arbitrator Doherty who found Petitioner's condition of ill-being remains causally related to his October 25, 2012 accidental injury and awarded the following benefits: Temporary Total Disability from December 12, 2012 through December 25, 2012 and January 16, 2013 through July 28, 2016; $826.92 in medical expenses as provided in Sections 8(a) and 8.2; and prospective medical care in the form the repeat EMG/NCV ordered by Dr. Fajardo. The Arbitrator further found Respondent entitled to credit for $72,518.12 in TTD benefits as well as any medical expenses paid. Petitioner's request for penalties and fees was denied.

The issues on Review are Petitioner's motion to strike the recitation of facts contained in Respondent's Statement of Exceptions due to violations of Supreme Court Rule 341(h)(6), causal connection of Petitioner's right elbow, wrist and hand conditions of ill-being, temporary total disability, prospective medical, and penalties and fees.

As a preliminary matter, the Commission denies Petitioner's motion to strike. While the Commission agrees Respondent's inclusion of argument and repeated use of bold typeface is neither appropriate nor necessary in a statement of facts, the Commission does not feel those

actions were sufficiently egregious to warrant striking the statement of facts. The Commission does, however, caution Respondent's Counsel against repeating this conduct in the future.

Further, the Commission, after reviewing the entire record, reverses the Arbitrator as to the issue of causation and finds Petitioner failed to prove a causal relationship between his October 25, 2012 work accident and his right elbow, wrist and hand conditions of ill-being. The Commission further remands this case to the Arbitrator for further proceedings for a determination of a further amount of temporary total compensation or of compensation for permanent disability, if any, pursuant to *Thomas v. Industrial Commission*, 78 Ill. 2d 327, 399 N.E.2d 1322, 35 Ill.Dec 794 (1980).

FINDINGS OF FACT

Petitioner was employed as a forklift driver by Respondent. T.9. In addition to picking and moving orders with the forklift, Petitioner also picked orders by hand; he estimated he manually moved over 300 boxes per day. T.10. The weights of the boxes varied, depending on the product, with some weighing up to 60 pounds; Petitioner testified these boxes were stacked on pallets and sometimes the height was over his head. T.10-11.

The parties stipulated Petitioner sustained an accidental injury arising out of and in the course of his employment on October 25, 2012. ArbX1. Petitioner described the accident as follows:

> So when I tried to pull the box that I needed, it's a big box, so I pushed it towards me so I could grab it with both of my hands - - with my other hand, my left hand. So the box went to its side and then went in front of me. I tried to stop it with the other hand, but the weight was great and it pulled my hand down. T.12.

Petitioner stated he felt "something cracking" in his right shoulder and severe pain. T.12. Petitioner's supervisor drove him to Riverside Medical Center that night. T.12-13. The emergency department records reflect Petitioner reported right shoulder pain rated at 8/10 after lifting a heavy box at work. Examination findings included limited and painful range of motion and occasional clicking with passive range of motion. The ER physician diagnosed a shoulder sprain, administered injections of Toradol and Norflex, restricted Petitioner to light duty, and directed him follow up at the occupational clinic in Monee. PX1.

On October 27, 2012, Petitioner presented to Riverside Corporate Health. The history of injury, as translated by his wife, indicates Petitioner was moving a 50-pound box when the weight shifted and he heard a crack in his right shoulder. He complained of sharp pain with movement and clicking with certain motions. Examination revealed pain with motion; tenderness to palpation in the bicipital groove, over the acromion, over the posterior shoulder, and along the scapular border; limited range of motion; decreased strength; positive crossover, empty can, Hawkins, Neer's and Yergason's tests; positive clunk with overhead movement; and inability to

perform Apley scratch test due to pain. The nurse practitioner diagnosed right shoulder pain and sprain/strain; she placed Petitioner in a sling, prescribed pain medications, and maintained Petitioner's modified duty status. PX2. At the October 31, 2012 re-evaluation, Petitioner reported no improvement in his symptoms and an MRI of the right shoulder was ordered. PX2.

The MRI was completed on November 5, 2012. The radiologist's impression was no evidence of rotator cuff tear or tendinopathy; fairly subtle abnormal signal involving the intra-articular component of the long head of the biceps tendon extending towards the biceps anchor, with possible partial tearing near the biceps anchor; no evidence of impingement syndrome; and mild arthrosis of the acromioclavicular joint. PX3. On review of the MRI, the occupational health nurse practitioner noted a SLAP tear and referred Petitioner for an orthopedic evaluation. PX2. Petitioner testified Respondent's nurse case manager made an appointment for him with Dr. Martin Hall at Keystone Orthopedics. T.14-15.

The initial consultation with Dr. Hall occurred on November 9, 2012. The records document a consistent history of the work injury: "There was a box that was coming off the shelf and he went to catch it with his right arm underneath and felt pain in his right shoulder." On exam, Dr. Hall noted marked tenderness in the proximal biceps tendon as well as crepitus and tenderness in the AC joint. With respect to the MRI, the doctor identified some irritation to the AC joint but no rotator cuff damage. Dr. Hall diagnosed biceps tendonitis and AC joint inflammation; he directed Petitioner to discontinue the sling, adjusted the pain medication, and ordered physical therapy. In the meantime, Petitioner was to continue restricted duty. PX3.

Over the next weeks, Petitioner attended physical therapy. The records evidence Petitioner garnered no significant improvement in his symptoms. On November 28, 2012, Dr. Hall injected Petitioner's right shoulder. When Petitioner was still symptomatic on December 12, 2012, Dr. Hall recommended arthroscopic repair. Petitioner was to remain on light duty pending surgery. PX3.

Petitioner testified Respondent modified his job duties by not having him move heavy boxes but he was still driving the forklift. He explained operating the lift involved manipulating a chest-height controller with his right hand. Petitioner stated this caused a lot of pain in his right shoulder and he missed work from December 12, 2012 through December 26, 2012. T.17-18. Respondent paid TTD benefits for that two week period. RX3.

In January of 2013, Petitioner obtained a second opinion from Dr. Marc Fajardo of Hinsdale Orthopaedics. Petitioner testified this was done at the recommendation of the nurse case manager. T.20. On review of the MRI, Dr. Fajardo observed a partial-thickness bursal sided tear over the insertion of the rotator cuff as well as elements of an anterior labral tear. Dr. Fajardo agreed with Dr. Hall's recommendation for arthroscopic exam. PX4.

Petitioner testified he began missing time from work on January 16, 2013. T.20.

On February 1, 2013, Petitioner was evaluated by Dr. Steven Chudik of Hinsdale Orthopaedics. Petitioner presented with right shoulder pain following a work injury; he stated he was lifting a 50 pound box off a shelf and the box slipped catching his right arm underneath and causing pain and a popping in the shoulder. He described the sensation as like someone was squeezing his shoulder and stated the pain occurred when reaching and lifting; Petitioner further stated the pain radiated down his right arm and reported tingling into his fingers. Examination findings included tenderness of the acromioclavicular joint and medial border of the scapula, pain with range of motion, decreased strength, positive Spurling's, and pain with belly press test; Dr. Chudik reviewed the MRI and noted swelling of the AC joint and signaling of the superior labrum. Dr. Chudik diagnosed cervical radiculopathy, right shoulder pain, and arthritis of the AC joint. Dr. Chudik recommended a diagnostic arthroscopy, authorized Petitioner off work, and administered an AC joint injection. PX4.

On February 19, 2013, Dr. Chudik performed right shoulder arthroscopy, arthroscopic capsular release, arthroscopic labral debridement, arthroscopic superior labral repair, arthroscopic resection of the biceps, arthroscopic subacromial decompression, arthroscopic distal clavicle resection, and open biceps tenodesis. At the close of the surgical procedure, Petitioner was placed in a sling. The postoperative diagnosis was right shoulder superior labral tear with an acromioclavicular joint injury with adhesive capsulitis, superior labral tear, proximal biceps rupture, impingement and damage to the acromioclavicular joint. PX4.

Post-operatively, Petitioner followed up with Dr. Chudik and at the doctor's direction remained off work and began physical therapy at ATI on February 22, 2013. PX7.

At the initial post-op appointment on February 25, 2013, Dr. Chudik observed swelling, effusion, and ecchymosis distal to the biceps incision. Dr. Chudik directed Petitioner to remain in his sling and continue off work while participating in physical therapy. When Petitioner was re-evaluated on March 6, 2013, the swelling, effusion, and ecchymosis had resolved; Dr. Chudik again recommended wearing the sling and continued therapy. PX4.

Petitioner next saw Dr. Chudik on April 15, 2013 and complained of pain in his bicep. On examination, Dr. Chudik noted tenderness at the AC joint and the biceps tendon at the bicipital groove; the upper extremity peripheral neurovascular and radicular neurologic exams were normal. Dr. Chudik discontinued the sling and advised Petitioner to limit his home exercises to what he was doing in formal therapy. PX4.

Respondent Tyson 4T's Management permanently closed its business on or about April 20, 2013. PX13.

Despite aggressive physical therapy over the next two months, Petitioner's pain complaints persisted. The July 11, 2013 progress report indicates Petitioner reported continuing right upper and posterior shoulder pain as well as right sided neck pain. PX7.

On July 15, 2013, Dr. Chudik documented Petitioner's peripheral neurovascular and radicular neurologic exams remained normal, but his strength and range of motion were diminished and elicited pain; Petitioner also had a positive Hawkins impingement sign. Due to Petitioner's slow progress, Dr. Chudik ordered an MRI. PX4.

The MRI was completed on July 25, 2013. The radiologist's impression was increasing edema near the acromioclavicular joint, possibly related to recent trauma; no abnormal signal in the rotator cuff to suggest tear or tendinopathy; and mild atrophy in the supraspinatus and infraspinatus muscles. After analyzing the scan, Dr. Chudik recommended arthroscopic capsular release and manipulation under anesthesia; Petitioner was to continue physical therapy pending surgery. PX4.

On August 22, 2013, Dr. Chudik performed a diagnostic arthroscopy of the glenohumeral joint, capsular release, and manipulation under anesthetic. The post-operative diagnosis was right shoulder pain and adhesive capsulitis. PX4.

Physical therapy recommenced on August 26, 2013. The September 4, 2013 progress report reflects Petitioner complained of right wrist pain extending to the elbow and into the last two digits with occasional numbness. PX7.

When Petitioner followed up with Dr. Chudik on September 6, 2013, he reported pain and stiffness during physical therapy. On examination, the doctor noted range of motion improving as expected and Petitioner was neurovascularly intact. Dr. Chudik directed Petitioner to stop wearing the sling, remain off work, and continue physical therapy; Petitioner was further advised to perform wrist motion with physical therapy to help swelling causing stiffness and tingling/numbness in fingers. PX4.

Petitioner next saw Dr. Chudik on October 2, 2013, and the records reflect he was still symptomatic: "Pain has not improved and shoulder is still stiff and immobile. He complains of pain up into the neck and significant neurological sensation deficits in the affected side hand." Examination revealed abnormal findings on peripheral neurovascular testing of the right radial, ulnar, and median nerves; abnormal findings on radicular neurologic testing at C6-8; tenderness at the trapezial musculature and medial border of the scapula; decreased range of motion; and decreased strength. Dr. Chudik maintained Petitioner's off work status and ordered ongoing physical therapy. PX4.

Petitioner reported similar complaints on November 13, 2013. Dr. Chudik recommended additional physical therapy and directed Petitioner to stretch diligently at home. PX4.

As of December 23, 2013, Petitioner's neurological sensation deficits had improved. He further advised he was stretching several times a day and his range of motion, strength, and pain were appreciably better. Additional therapy was ordered. PX4.

The January 28, 2014 physical therapy progress note indicates Petitioner complained of continued right shoulder pain and tightness and he also stated he had numbness in the forearm/fingers and discoloration in the hand. PX7.

When Petitioner next saw Dr. Chudik on February 3, 2014, he reported the improvement in his range of motion and strength had plateaued; Petitioner further indicated his hand felt weak and he had numbness and tingling in the hand when doing his exercises. Examination findings included abnormal radicular neurologic testing at C6-T1; tenderness of the trapezial musculature, AC joint, and biceps tendon at the bicipital groove; decreased range of motion; and positive Spurling's, Neer's, and Hawkins tests. Dr. Chudik kept Petitioner fully restricted from work and ordered an FCE. PX4.

The FCE was performed at ATI on February 19, 2014. The report indicates the test is valid and places Petitioner at the Light Physical Demand Level. Petitioner's job as a Material Handler is considered a Heavy PDL occupation. PX5.

On March 10, 2014, Petitioner followed up with Dr. Chudik. Petitioner complained of significant painful cracking and popping in the shoulder with use and reported his hand weakness and numbness and tingling persisted without improvement. Concluding cervical radiculopathy may be contributing to the unresolved shoulder symptoms, Dr. Chudik ordered a cervical spine MRI and referred Petitioner to Dr. Mark Lorenz for a neck evaluation. PX4.

The cervical spine MRI was completed on June 6, 2014. The radiologist's impression was minor bulging of the C5-6 disc with mild foraminal narrowing on the left and right; no large disc herniation or severe central canal stenosis was noted. PX4.

The neck evaluation occurred on July 9, 2014. Petitioner gave a history of neck and right arm pain following the 2012 work accident. He also complained of numbness along the medial forearm and into the last three digits on the right hand, worse with looking side to side. Examination findings included decreased upper extremity strength on the right side, sensory diminished to light touch along the medial forearm and last three digits, and negative Tinel's sign; as the MRI was negative for significant stenosis or herniation, the recommendation was for physical therapy as well as an EMG/NCS of the right upper extremity. PX4.

The cervical spine physical therapy initial evaluation took place on July 17, 2014. PX7.

On July 23, 2014, Dr. Steven Bardfield conducted the recommended EMG/NCS. The report indicates all nerve conduction studies were normal, including inching across the elbow, and the needle EMG of all tested muscles was normal. Dr. Bardfield's conclusion was normal EMG/NCS with no electrical evidence of neuromuscular disease. PX4.

On September 11, 2014, Petitioner followed up with Dr. Lorenz. Noting the EMG was "totally normal," Dr. Lorenz recorded Petitioner "still complained of a sensation of numbness in

the right forearm which at this point in time, I cannot explain." The doctor further noted Petitioner continued to complain of neck pain in spite of a normal neck exam and negative cervical spine MRI. As there was no evidence of radiculopathy or degenerative change in the cervical spine, Dr. Lorenz opined Petitioner had a soft tissue issue and did not require further spine care. The doctor referred Petitioner to Dr. Bardfield for chronic neck pain and to Dr. Fajardo for a second opinion regarding the persistent subjective numbness sensation in his forearm. PX4.

The consultation with Dr. Fajardo occurred later on September 11, 2014. The doctor recorded Petitioner had a two-year history of right hand numbness following an injury when "a heavy box fell on his right arm," and Dr. Lorenz had ruled out spine etiology. Petitioner's chief complaint was small and ring finger numbness which affected his activities of daily living and at work. On exam, Dr. Fajardo observed no swelling, ecchymosis or erythema at the hand/wrist, provocative maneuvers of the wrist and hand were negative, sensory was intact to light touch over the median and radial nerves but decreased over the ulnar nerve, positive Durkan, positive Tinel's at both the wrist and elbow, and positive elbow flexion test. On review of the EMG/NCS, Dr. Fajardo noted the ulnar nerve velocity differential was not done but the EMG portion was within normal limits. Dr. Fajardo concluded Petitioner had clinical symptoms of right cubital tunnel syndrome. The doctor injected the right cubital tunnel and advised Petitioner to sleep with his elbow extended. PX4.

Petitioner was evaluated by Dr. Bardfield on September 24, 2014. Petitioner complained of pain in the right side of the neck with numbness and tingling down the right arm. On exam, Dr. Bardfield noted limited cervical range of motion, tenderness from the right paraspinal to the right scapular region, and significant tenderness over the right scalene muscle which re-created referred pain into the right arm. Dr. Bardfield's assessment was cervical pain with apparent spasm of the scalene and upper trapezius musculature possibly causing referred paresthesias into the arm. The doctor prescribed a Medrol Dosepak and directed the physical therapist to focus treatment on the scalene and trapezius muscle to address postural abnormalities which could be contributing to Petitioner's symptoms. PX4.

On September 24, 2014, Petitioner was re-evaluated by Dr. Chudik. He advised the doctor his shoulder had not improved and stated he could not do simple tasks such as reaching for items in a cabinet or picking up an object that requires grasping with his hand; Petitioner also described ongoing painful cracking and popping in the shoulder. Physical examination findings included tenderness at the spine of the scapula and the biceps tendon at the bicipital groove, decreased active elevation, and pain with strength testing. Dr. Chudik placed Petitioner at maximum medical improvement for the shoulder and released him with permanent restrictions per the FCE. PX4.

Petitioner followed up with Dr. Fajardo on October 24, 2014 and reported his elbow symptoms improved following the cubital tunnel steroid injection but he continued to have hand numbness and weakness. Dr. Fajardo concluded Petitioner had clinical symptoms of cubital

tunnel syndrome and carpal tunnel syndrome; the doctor administered a steroid injection to the carpal tunnel, recommended use of a wrist guard and NSAIDs as needed, and released Petitioner to follow up as needed. PX4.

Petitioner also saw Dr. Bardfield on October 24. The records reflect Petitioner had completed additional therapy without reported benefit. Petitioner stated whenever he did lifting or activities involving the arm the muscular area in the neck, upper back, and right side was tight. Dr. Bardfield's assessment was cervical myofascial pain status post shoulder surgery. As Petitioner had maximized his progress in physical therapy and could not return to work as a forklift driver, the doctor recommended home exercises and vocational retraining. PX4.

Petitioner last saw Dr. Fajardo on November 19, 2014. He advised the doctor the wrist injection did not help much and complained of hand numbness and weakness. Noting Petitioner had clinical symptoms of cubital tunnel syndrome and carpal tunnel syndrome, Dr. Fajardo ordered a repeat EMG/NCS to be done by a neurologist. In the meantime, Petitioner was to remain off work. PX4.

On September 3, 2015, Dr. Michael Cohen performed a Section 12 examination and record review at Respondent's request. RX1, DepX3. Dr. Cohen recorded Petitioner reported an onset of numbness and tingling in the right ulnar distribution dating back to the first surgery. On examination, Dr. Cohen noted negative Tinel's over the cubital tunnel, partial subluxation of the ulnar nerve with elbow flexion, and nonphysiologic findings on two-point discrimination in the ring and little finger. The doctor further noted Petitioner's subjective complaints far exceeded his objective findings. Dr. Cohen opined Petitioner was near maximum medical improvement regarding his shoulder and recommended a brief course of work hardening followed by an FCE with validity testing. Dr. Cohen indicated he questioned the validity of the February FCE but offered no explanation as to why beyond stating he had "concerns based on the readings of some of the testing within it." Dr. Cohen additionally noted Petitioner had ongoing symptoms of cubital tunnel syndrome but opined there was no causal relationship to the 2012 work injury. The doctor observed Petitioner slept with his elbow in a hyperflexed position which could cause the cubital tunnel symptomatology and recommended a nighttime splint. RX1, DepX3.

The evidence deposition of Dr. Fajardo was taken on April 20, 2016 and admitted as Petitioner's Exhibit 6. Dr. Fajardo concentrates his elective practice on the upper extremity, predominantly the hand and shoulder; he is board certified in orthopaedic surgery. PX6, p.5-6. Dr. Fajardo testified he evaluated Petitioner for right hand and elbow numbness on September 11, 2014. PX6, p.8. The doctor explained Petitioner had a positive Durkan, which tests the median or carpal tunnel nerve, as well as positive Tinel's at the elbow and elbow flexion sign, both of which are characteristic of ulnar symptoms. PX6, p.10. Dr. Fajardo administered a steroid injection into the right cubital tunnel which he testified was for both diagnostic and therapeutic purposes. PX6, p.10. Dr. Fajardo also reviewed the July 23, 2014 EMG during that evaluation. PX6, p.9. In his report, he observed a nerve conduction velocity had not been done. Dr. Fajardo testified that omission is significant because velocity testing which demonstrates an

increased difference between above and below the elbow is very characteristic of cubital tunnel syndrome. PX6, p.11.

When Petitioner followed up on October 24, 2014, he reported the injection eased his elbow symptoms; Dr. Fajardo testified this indicated Petitioner likely had cubital tunnel syndrome. PX6, p.12. The doctor concluded Petitioner had clinical signs of cubital tunnel syndrome and carpal tunnel syndrome, administered an injection into the carpal tunnel, again for therapeutic and diagnostic purposes, and prescribed a wrist guard. PX6, p.13. Dr. Fajardo testified he next saw Petitioner on November 19, 2014. Petitioner reported transient improvement in his symptoms following the injection but the weakness and numbness over the hand persisted. PX6, p.13. The doctor stated his notes indicate Petitioner's numbness began after his second surgery. PX6, p.13-14. Petitioner's examination findings were unchanged with weakness over the ulnar nerve muscles and positive Durkan and Tinel's at the wrist. PX6, p.14. Diagnosing carpal and cubital tunnel syndromes, he recommended a repeat EMG by a neurologist. PX6, p.14. Dr. Fajardo explained why he felt a repeat study was necessary:

> Well, not all machines are equal. The newer machines are more specific, more sensitive. Different doctors have different techniques of how to perform the EMG/nerve conduction study. To do these tests, it's more of an art. It's not a science. So a second EMG by a neurologist who is more specialized with peripheral nerve problems, I thought was in order because the patient wasn't getting better with my injections and for a second opinion. PX6, p.15.

When asked his opinion as to whether the swelling and numbness in Petitioner's right arm and hand were complications from the two surgeries, Dr. Fajardo stated it is not uncommon to have swelling in the hand and wrist after surgery, noted such swelling can continue for several months after shoulder surgery, and opined this happened in Petitioner's case: "The patient had two surgeries. So after the second surgery, he's going to have more inflammation, more swelling. Gravity will bring this to the hand and the wrist and elbow." PX6, p.16. As to whether or not post-surgical swelling was a causative factor in the cubital and carpal tunnel syndrome symptoms and findings he made with Petitioner, Dr. Fajardo stated, "So it's atypical to develop these symptoms from surgery. But can it happen? Yes." PX6, p.17. The doctor testified carpal tunnel syndrome is multifactorial with multiple risk factors and stated Petitioner did not have any of the normal risk factors for developing carpal or cubital tunnel syndrome. PX6, p.17. Dr. Fajardo was next asked whether the cubital tunnel syndrome in this case may have been caused by the immobilization of the right elbow following the surgeries; he responded as follows:

> ...he was immobilized for a month. Do I think that this immobilization would have caused it? I think it's a combination of factors. I think it's due to the post-op swelling and the immobilization, but I don't think it's a direct cause. If the patient was in a sling or immobilized for more than several months with his arm flexed, then I would say that's more predictive. PX6, p.18.

On cross-examination, Dr. Fajardo further detailed the basis of his opinion the hand numbness was attributable to the shoulder surgery:

> Well, his case is different, Ken, because this is his second surgery. It was not just an arthroscopy that Dr. Chudik did. He did a manipulation, which causes more trauma over the shoulder and arm. Because of all this, he's going to have more swelling, more inflammation, more pain. This swelling and inflammation often comes down to the distal part of your hand and your fingertips because gravity will bring that all down. That's why people are immobilized in a sling, to keep the swelling down. PX6, p.21.

The doctor explained he has treated three or four patients with carpal tunnel syndrome after shoulder surgery performed by different physicians. PX6, p.22. Dr. Fajardo was then presented with the July 23, 2014 EMG; he agreed the EMG was interpreted as being normal and further agreed the study contained some velocity readings but testified it was incomplete because "he lists velocity only below the elbow and not above." PX6, p.23. The doctor testified, based on the finding of the nerve conduction study, Petitioner's carpal tunnel is within normal limits. PX6, p.24. He continued, however, stating that did not preclude a diagnosis of carpal tunnel syndrome: "So roughly 15 to 20 percent of the population can have symptomatic carpal tunnel with a normal EMG/nerve conduction study. This is documented. This is in research." PX6, p.24. Dr. Fajardo testified there was no need for a repeat EMG for the wrist; rather, the only fault was with respect to the elbow and the lack of comparison between above and below the elbow. PX6, p.25.

The evidence deposition of Dr. Michael Cohen was taken on May 11, 2016 and admitted as Respondent's Exhibit 1. Dr. Cohen is board certified in orthopedics with an added qualification in hand surgery. RX1, p.5. He testified 100 percent of his practice is upper extremity: 20% is shoulder and 80% is below the shoulder. RX1, p.6. Dr. Cohen issued multiple Section 12 reports regarding Petitioner but his deposition was focused on the medical treatment and diagnostics recommended by Dr. Fajardo in late 2014 which was the subject of Dr. Cohen's September 3, 2015 report. Dr. Cohen testified he could not confirm Dr. Fajardo's diagnosis of carpal tunnel syndrome; the doctor explained Petitioner had subjective complaints which could be consistent with carpal tunnel syndrome, but his physical examination did not point to carpal tunnel syndrome, and Petitioner's complaints were not necessarily physiologic when testing his two-point discrimination. RX1, p.12. Dr. Cohen was then presented with the July 23, 2014 EMG and asked whether he agreed with Dr. Fajardo's statement the test was inconclusive[1]. Dr. Cohen explained his disagreement with Dr. Fajardo:

> Well, assuming I understand Dr. Fajardo's opinion is Dr. Fajardo's opinion is it was not an above and below the elbow study so as what we would routinely see for a EMG looking at cubital tunnel syndrome; and I would agree this is not typical.

[1] The Commission clarifies Dr. Fajardo did not testify the July 23, 2014 EMG/NCV was "inconclusive"; rather, the term Dr. Fajardo used was "incomplete". PX6, p.23.

> However, counter to Dr. Fajardo's opinion, this EMG would be in excess of what the normal EMG; *i.e.*, the above and below is, not less than that.
> This EMG does what's called an inching technique which is going across the elbow in small sectors, so instead of having one measurement above and one measurement below and comparing those, this actually has four measurements across the elbow, hence they call - - I mean this is - - they call it the inching technique not necessarily to imply that each measurement is one inch apart, but it's several measurements across the area of the course of the ulnar nerve as opposed to two.
> So this is actually more detailed, if you will, than what the typical would be. RX1, p.14-15.

Dr. Cohen further stated the inching technique is a focal diagnostic for cubital tunnel syndrome, and the July 23, 2014 EMG does not show any evidence of cubital tunnel syndrome. RX1, p.16. The doctor testified the report details four sites, which should be two above the elbow and two below; cubital tunnel syndrome is evidenced by a significant drop in amplitude across the elbow but no such drop is present in this study. RX1, p.18. Dr. Cohen opined the proper treatment to address Petitioner's symptoms is nighttime splinting to prevent Petitioner from sleeping with his elbow in a hyperflexed position. RX1, p.21. Dr. Cohen was then asked to respond to Dr. Fajardo's opinion Petitioner's elbow and wrist symptoms were a result of his shoulder surgery:

> Yes, I disagree with that. First of all, we have some issues with the diagnosis.
> The numbness and tingling that he has at the time that I see him in September of 2015 is in the middle ring and little finger which would not be carpal at all, so that's a problem.
> He has a normal EMG for carpal tunnel. He has a normal EMG for cubital tunnel syndrome.
> He sleeps with his elbow in a hyperflexed position which is the No. 1 cause of this, of cubital tunnel syndrome.
> And he also has some ulnar nerve subluxation at the elbow. So unless that - - and I - - I'm going to go a little hypothetical which I don't like to do, but I don't know how else to explain this, unless Dr. Fajardo is saying that Dr. Chudik caused a direct injury to Mr. Gallardo's elbow causing the subluxation of the ulnar nerve which I see no evidence of, so I don't want to confuse anyone, but that ulnar nerve subluxation clearly predated this event and these issues. And that would be another risk factor for cubital tunnel syndrome that has nothing to with the surgery. RX1, p.22-23.

On cross-examination, Dr. Cohen testified he does approximately 100 Section 12 examinations per year, 80-90% of which are on behalf of respondents. RX1, p.26. The doctor further stated complaints of numbness in the small and ring finger could be consistent with cubital tunnel syndrome. RX1, p.29. As to Petitioner's hand examination findings, Dr. Cohen

explained Petitioner had no Tinel's phenomenon on the cubital tunnel. RX1, p.34. Dr. Cohen also reiterated the inching technique is the most specific EMG testing protocol for diagnosing cubital tunnel syndrome. RX1, p.36.

Surveillance video was admitted into evidence as Respondent's Exhibit 5. All told there is 1:13:29 of video which was filmed over nine days in March, September and November of 2015. The Commission has viewed the video in its entirety. The vast majority of the video is of Petitioner with youngsters who are presumably his children: he is seen walking a young girl to the school bus stop, pushing an infant in a stroller through a park, and with the same baby while running errands. Petitioner does lift the baby but the infant appears to weigh no more than 12 to 15 pounds, consistent with Petitioner's testimony. The Commission also notes Petitioner lifts predominantly with his left arm when moving the stroller in and out of his vehicle. The most significant activity captured on the video is from September 29, 2015. During a 21-second segment, Petitioner is on the third step of a six-foot A-frame step ladder, descends, uses both hands to move the ladder over, then climbs back up; Petitioner appears to be cleaning the gutter but the camera angle does not actually show Petitioner's actions. Petitioner is also seen carrying a garden shovel in his left hand then, for less than 30 seconds, Petitioner uses both hands on the shovel to scrape the gutter detritus from the bushes.

CONCLUSIONS OF LAW

I. CAUSAL CONNECTION

There are two conflicting medical opinions regarding Petitioner's right elbow, wrist and hand conditions of ill-being: Dr. Fajardo's and Dr. Cohen's. Dr. Fajardo concludes Petitioner has carpal tunnel syndrome as well as cubital tunnel syndrome and opines these diagnoses are related to the swelling, inflammation, and immobilization resulting from Petitioner's two shoulder surgeries. Dr. Cohen, on the other hand, disagrees with the diagnosis of carpal tunnel syndrome and further concludes any cubital tunnel syndrome symptoms are associated with Petitioner's pre-existing ulnar nerve subluxation as well as his habit of sleeping with his elbow in a hyperflexed position.

The Commission finds Petitioner failed to prove his right shoulder injury resulted in carpal tunnel syndrome. In doing so, the Commission notes the July 23, 2014 EMG demonstrated Petitioner's carpal tunnel was within normal limits. The Commission recognizes Dr. Fajardo testified what may be termed false negative EMGs occur up to 20% of the time and the Commission does not question the accuracy of the doctor's statement; however, the Commission emphasizes Dr. Fajardo also testified the steroid injection he administered to Petitioner's right carpal tunnel was diagnostic and the medical records evidence that injection was of little to no benefit. As such, the result of Dr. Fajardo's diagnostic intervention is inconsistent with a diagnosis of carpal tunnel syndrome. The Commission further emphasizes Dr. Cohen's testimony that Petitioner's physical examination findings did not point to a diagnosis of carpal tunnel syndrome. The Commission finds the objective medical evidence is most consistent

with Dr. Cohen's conclusions and assigns great weight to Dr. Cohen's opinions. The Commission finds Petitioner failed to prove he has carpal tunnel syndrome as sequelae of his shoulder injury.

The Commission finds Petitioner failed to prove his right shoulder injury resulted in cubital tunnel syndrome. The Commission again highlights the July 23, 2014 EMG was negative. While Dr. Fajardo opines the EMG was incomplete, the Commission finds more credible Dr. Cohen's testimony detailing why the inching technique utilized was superior and was in effect the gold standard method for diagnosing cubital tunnel syndrome. The Commission additionally notes Dr. Cohen's testimony identifying Petitioner's pre-existing ulnar nerve subluxation as well as his sleep posture as significant risk factors for cubital tunnel syndrome wholly unconnected to the shoulder surgeries. The Commission finds Dr. Cohen's conclusion that Petitioner's symptoms are not related to the shoulder surgeries to be most credible and persuasive. The Commission finds Petitioner failed to prove his right shoulder injury resulted in cubital tunnel syndrome.

The Commission finds Petitioner failed to prove his right elbow, wrist and hand conditions of ill-being are causally related to his October 25, 2012 shoulder injury. The Commission further finds Petitioner reached maximum medical improvement for his right shoulder injury on September 24, 2014, the date Dr. Chudik released him with permanent restrictions per the FCE.

II. TEMPORARY TOTAL DISABILITY

Based on the determination Petitioner reached maximum medical improvement for his right shoulder condition on September 24, 2014, the Commission finds Petitioner was temporarily and totally disabled for 90 $^{1}/_{7}$ weeks, representing December 12, 2012 through December 26, 2012 and January 16, 2013 through September 24, 2014.

III. MEDICAL

Petitioner offered into evidence three medical bills. Petitioner's Exhibit 8 is a $64.00 charge from Central Illinois Radiological Associates for shoulder x-rays on the date of accident. The account ledger reflects this bill was placed in collections and written off. Pursuant to the fee schedule, the amount is $60.63. Petitioner's Exhibit 9 is a $42.00 charge from Suburban Radiologists for chest x-rays on February 13, 2013. The fee schedule amount is $38.65. Petitioner's Exhibit 10 is a $1,315.00 bill from Riverside Medical Center for services rendered on October 25, 2012 and October 26, 2012. Adjusted pursuant to the fee schedule, the bill totals $727.64.

The Commission finds these expenses were reasonable and necessary and related to Petitioner's right shoulder injury and accordingly awards payment of the same.

IV. PROSPECTIVE MEDICAL

In light of its causation determination, the Commission finds the repeat EMG/NCV is not reasonably required to cure the effects of the accidental injury and denies same.

V. PENALTIES AND FEES

In his brief on Review, Petitioner argues penalties and fees are warranted because Respondent failed to prove its refusal to pay TTD after December 9, 2015 as well as certain medical expenses was reasonable. With respect to the TTD benefits after December 9, 2015, the Commission notes it found Petitioner reached MMI on September 24, 2014; as such, Respondent paid TTD benefits through the period required by the Act. The issue of whether Petitioner was entitled to vocational rehabilitation and associated maintenance benefits thereafter was not presented and the Commission will not comment.

As to the unpaid medical bills, Respondent's Counsel stated on the record that the hearing was the first time he became aware of the unpaid bills. T.42. In response, Petitioner's Counsel stated he had forwarded the bills on multiple occasions and also noted a penalties petition had been filed. The Commission has reviewed the penalties petition and notes there is no mention of unpaid medical expenses therein. PX15. The Commission has also examined the correspondence Petitioner's Counsel sent attaching the bills and observes there is a discrepancy between the recipient email address used therein (kfsmith@travelers.com) and Respondent's Counsel's sender email address when he forwarded the wage statement to Petitioner's Counsel (ksmith13@travelers.com). The Commission accepts Respondent's Counsel's word as an officer of the court that the hearing date was the first he became aware of the unpaid balances and finds there was no refusal to pay same. The Commission denies the request for penalties and fees.

IT IS THEREFORE ORDERED BY THE COMMISSION that Petitioner failed to prove a causal relationship between the October 25, 2012 shoulder injury and his right elbow, wrist and hand conditions of ill-being.

IT IS FURTHER ORDERED BY THE COMMISSION that Petitioner's right shoulder condition of ill-being reached maximum medical improvement on September 24, 2014.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $480.65 per week for a period of 90 1/7 weeks, that being the period of temporary total incapacity for work under §8(b) of the Act. Pursuant to the parties' stipulation, Respondent shall receive a credit of $72,518.12 for temporary total disability benefits paid.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent is to pay the sum of $826.92 for medical expenses pursuant to §§8(a) and 8.2 of the Act, as those expenses were incurred for treatment of Petitioner's right shoulder condition.

IT IS FURTHER ORDERED BY THE COMMISSION that the EMG/NCV ordered by Dr. Fajardo is denied.

IT IS FURTHER ORDERED BY THE COMMISSION that the request for penalties and fees is denied.

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 without the filing of such written request, or after the time of completion of any judicial proceedings, if such 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.

As the amount paid by Respondent exceeds the award, no bond is set by the Commission. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 2 1 2017

L. Elizabeth Coppoletti

Charles J. DeVriendt

Joshua D. Luskin

LEC/mck

O: 6/21/17

43

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

MARK SCHMIDT,

Petitioner,

vs. NO: 14 WC 3252

CHICAGO TRANSIT AUTHORITY,

Respondent.

17IWCC0521

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 Arbitrator found that Dr. Shah had recommended additional injections but these were not approved. Respondent argues that there is no evidence for this finding because Respondent's hearsay objections relating to Petitioner's testimony regarding the lack of approval for the injections were sustained by the Arbitrator. We agree and hereby strike the references to the injections not being approved. (Dec. at 4 and 5).

The Arbitrator wrote, "It is undisputed that Petitioner was off work from March 18, 2013 to May 5, 2014." (Dec. at 5). However, this is a typographical error since it was stipulated that Petitioner was off work from March 18, 2014 to May 5, 2014. We hereby correct the decision to reflect that Petitioner's first day off work was March 18, 2014, not 2013.

On the issue of nature and extent, we find that the weighing of the five factors in §8.1b(b) of the Act results in a permanency award of 20% loss of use of the right leg.

For the first factor, the Arbitrator found that "no permanent partial disability impairment report and/or opinion was submitted into evidence" and gave no weight to this factor. (Dec. 4). Respondent argues that this is incorrect because, on May 5, 2014, Dr. Shah wrote, "At this point he can return to work full duty. He is at maximum medical improvement as of 05/05/14.

Impairment rating is zero." The Commission finds that this statement by Dr. Shah is not a "report" as contemplated under §8.1b(a) nor is there any indication that this impairment rating "opinion" was determined based upon "[t]he most current edition of the American Medical Association's 'Guides to the Evaluation of Permanent Impairment'" as required under that section. We also note that, even if Dr. Shah's statement on May 5, 2014 was intended to be an AMA impairment rating, it was not contained within a written AMA impairment report as required by the Act. Furthermore, Petitioner returned to Dr. Shah in September 2014 and August 2016 with additional complaints and for further treatment, after which a new impairment rating was not given. We find that Dr. Shah's statement does not constitute an AMA impairment rating under 8.1b(a). Therefore, the Arbitrator properly gave no weight to this under the first factor.

Regarding the second factor, the "occupation of the injured employee," the Arbitrator wrote that Petitioner was employed as a "lineman/electrician at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury." (Dec. at 4). The Commission corrects the decision to reflect that Petition was a bus and truck mechanic and not a lineman/electrician at the time of the accident. (T.8). We also note that Petitioner testified that when he returned to work at his previous job his right knee affected his ability to perform his work. Petitioner testified that he had pain going up and down ladders, squatting, and kneeling. His work partner would perform tasks that required kneeling or stooping down and Petitioner would do more of the "standing" tasks. (T.24-25). Petitioner testified on cross-examination that, approximately one year prior to the hearing, he received a promotion to assistant foreman, which involves more office work and walking. He no longer physically uses his tools to repair buses but he testified that he could be "put back on the floor" at any time. (T.33-34). On redirect examination, Petitioner testified that if Respondent determines that more mechanics are needed on the floor, he would have to perform those duties. He testified that "walking is good" but his current position requires a lot of stair climbing to get the repair orders and climbing ladders to go into the buses to make sure the mechanics are doing their jobs. Petitioner testified that his knee feels better going up stairs or ladders than going down. He uses the handrail because his knee feels tender and he's cautious about it. (T.37-39). We find Petitioner credible that, although he was returned to work full duty in his previous position, he did so with some difficulty and self-imposed work modifications due to his continued symptoms. We agree with the Arbitrator's finding that this factor deserves greater weight.

For the third factor, we note that the Arbitrator did not specify Petitioner's age in this section. We hereby correct this omission by finding that Petitioner was 60 years old at the time of the injury. We affirm the remainder of the analysis of this factor.

The Commission affirms the Arbitrator's analysis of the fourth factor ("future earning capacity").

Regarding the fifth factor ("evidence of disability corroborated by the treating medical records"), we find that the Arbitrator gave too much weight to this factor. Petitioner's testimony regarding complaints of popping, grinding, and pain with certain activities is corroborated by Dr. Shah's records. On September 22, 2014, Dr. Shah documented Petitioner's complaints of patellar clunking with painful popping. On August 1, 2016, Dr. Shah wrote that Petitioner felt about 85-90% better compared to prior to the surgery but "continued to have pain, kneeling pain, pain deep to the kneecap." Petitioner's examination was positive for clicking and he did have some popping that was occasionally painful with crepitus in the patellofemoral joint, but he had no instability or giving out episodes. Although Petitioner testified about having pain with certain activities and being cautious, we find that he did not specifically testify about having any

17IWCC0521

strength or range of motion issues. Even if he had, and to the extent that his testimony could be interpreted as such, we find that these complaints are not corroborated by the medical records. On May 5, 2014, Dr. Shah noted that Petitioner had full range of motion and full strength and significantly improved pain, although he had occasional soreness and swelling which was improving. The subsequent visits to Dr. Shah do not support a finding that his range of motion or strength had diminished. We find that many of the considerations discussed by the Arbitrator under this factor are also elements of the second factor relating to his occupation. We find that Petitioner has some evidence of disability corroborated by the medical records but not to the degree that the Arbitrator found. Accordingly, we give this factor some weight.

We hereby modify the permanency award to 20% loss of use of the right leg. The decision is further modified to reflect the corrections noted above. All else is affirmed and adopted.

IT IS THERFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $712.55 per week for a period of 43 weeks, as provided in §8(e) of the Act, for the reason that the injuries sustained caused the 20% loss of use of the right leg.

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 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

CJD/se
O:7/26/17
49

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

SCHMIDT, MARK
Employee/Petitioner

Case# **14WC003252**

CHICAGO TRANSIT AUTHORITY
Employer/Respondent

17IWCC0521

On 1/6/2017, 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 0.63% 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:

4564 ARGIONIS & ASSOCIATES LLC
LOUKAS N KALLIANTASIS
180 N LASALLE ST SUITE 2105
CHICAGO, IL 60601

0515 CHICAGO TRANSIT AUTHORITY
J BARRETT LONG
567 W LAKE ST 6TH FL
CHICAGO, IL 60661

STATE OF ILLINOIS)
)SS.
COUNTY OF COOK)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

MARK SCHMIDT,
Employee/Petitioner

v.

CHICAGO TRANSIT AUTHORITY,
Employer/Respondent

Case # 14 WC 3252

Consolidated cases: ____

17IWCC0521

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **MARIA BOCANEGRA**, Arbitrator of the Commission, in the city of **CHICAGO** on **October 20, 2016**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **February 20, 2013**, Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, Petitioner earned **$89,772.80**; the average weekly wage was **$1,726.40**

On the date of accident, Petitioner was **60** years of age, ***married*** with 0 dependent children.

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

Respondent shall be given a credit of **$8,057.00** for TTD, **$0** for TPD, **$0** for maintenance, and **$0** for other benefits, for a total credit of **$8,057.00**. Respondent is entitled to a credit of **$n/a** under Section 8(j) of the Act.

ORDER

Based on the §8.1b factors and the record taken as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for **54.825 weeks**, because the injuries sustained caused the **25.5%** loss of the **right leg**, as provided in Section **8(e)**.

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

1-4-2017
Date

JAN 6 - 2017

FINDINGS OF FACT

It is undisputed that on February 20, 2013, Mark Schmidt ("Petitioner") suffered a traumatic injury to his right knee that arose out of and in the course of his employment with the Chicago Transit Authority ("Respondent"). Petitioner testified that on February 20, 2013, he was working as a mechanic at the Chicago Transit authority and was assigned to work on the diesel engine and replace a muffler on a Chicago Transit Authority bus. Petitioner testified that his job duties included kneeling down to repair bus engines and climbing ladders and stairs. Petitioner testified that during his work, on February 20, 2013, he knelt down to work on the engine. Petitioner testified that his knee twisted, felt a pop and felt an immediate onset of pain in his right knee, stemming from inside his knee. Petitioner testified that he had never felt this type of pain in his knee prior to February 20, 2013. Petitioner testified that he reported the incident to his supervisor on the same day.

Petitioner testified that he did not seek immediate medical treatment because he hoped his knee would improve. He testified that his knee did not improve and then sought medical treatment. He testified that on March 6, 2013, he treated with Dr. Nirav Shah at Parkview Orthopeadics and complained of right knee pain. Px1. He indicated that he was injured while working when he felt a "pop" in his knee while performing his duties. *Id.* Petitioner further indicated that he felt a grinding noise as well as pain. *Id.* He testified that his knee felt unstable at that time. He further testified that he continued to work at this time. Dr. Shah ordered the Petitioner to begin physical therapy and prescribed pain medication. Px7. He testified that the doctor ordered him to wear a knee brace while working. *Id.* Petitioner testified that he underwent 11 visits of physical therapy at Parkview Orthopaedics. Petitioner testified that the therapy provided temporary relief, but that his knee continued to feel weak and unstable.

Petitioner testified that he returned to Dr. Shah on August 6, 2013. Px1:40. Dr. Shah recommended and administered a cortisone injection in Petitioner's right knee. *Id.* Dr. Shah recommended further physical therapy. Petitioner testified that the injection provided temporary pain relief, but that his knee continued to feel unstable. Petitioner testified that his knee pain returned and he once again presented to Dr. Shah on October 30, 2016. Dr. Shah ordered an MRI of his right knee, which showed a partial tear of the anterior cruciate ligament near the tibial attachment, and a tear of the posterior horns of the lateral and medial menisci.

Following the diagnostic testing, Petitioner followed-up with Dr. Shah on December 30, 2013. Dr. Shah noted a meniscus tear, partial ACL tear, and patellar tendinopathy. *Id.* Dr. Shah further noted that Petitioner's symptoms had not improved and that Petitioner continued to have pain while stair climbing and kneeling. *Id.* On said date, Dr. Shah recommended arthroscopic surgery. *Id.*

On March 18, 2014, Dr. Shah performed a right knee arthroscopy with partial medial meniscectomy, abrasion arthroplasty of the patellofemoral joint and femoral trochlea, patellar tendon debridement, arthrotomy, and excision of the Hoffa fat pad. Px1:60. The post-operative diagnosis was right knee patellofemoral chondromalacia, right knee medial meniscus tear, right knee patellar tendinitis and tendinosis, and right knee Hoffa fat pad syndrome. *Id.* Petitioner returned to Dr. Shah on March 19, 2016. The doctor recommended Petitioner start therapy and remain off work. Petitioner underwent 9 therapy sessions at Parkview Orthopaedic Group between March 31, 2014 and April 24, 2014. Petitioner testified that therapy improved his symptoms but his knee continued to feel weaker than its pre-injury state.

On May 5, 2014, Dr. Shah released Petitioner to work full duty. Petitioner testified that his knee felt better but felt weaker and sorer compared to his pre-injury state. Petitioner testified that his right knee affected his ability to perform his work. Petitioner testified that he relies on help from his work partners to complete a job. Petitioner further testified that he also had a difficult time climbing ladders or kneeling down. Petitioner testified that he also would perform his work more slowly than prior to his injury. Petitioner testified that his

knee would be sore and painful after a day of work and that he would take over the counter pain medication to address the pain.

Petitioner testified that his knee would periodically click and feel unstable. Petitioner testified that he returned to Dr. Shah on September 22, 2014, for this issue. Petitioner complained of clunking and popping in his knee. Dr. Shah suspected scar tissue involvement and ordered a new MRI. Dr. Shah recommended further injections but these were ultimately not approved. On August 1, 2016, Petitioner saw Dr. Shah one final time. He continued to feel periodic pain and clicking in his right knee. Petitioner reported that his knee felt 85% improved since his pre-surgery condition. The doctor again recommended injections, which were not approved.

Petitioner testified that he suffered a sprained knee during high school football, sometime in the 1970s. Petitioner testified that this injury was of a soft-tissue nature and that the injury resolved within four to six weeks. From this point up until February 20, 2013, Petitioner testified that he did not suffer any injury to his right knee. Petitioner testified that, prior to February 20, 2013, he did not have any pain or other problems with his right knee after his high school football injury. Petitioner testified that he did not re-injure his right knee after February 20, 2013. Petitioner testified that his knee currently hurts him when kneeling down, climbing stairs and ladders, and descending stairs and ladders. Petitioner testified that he received a promotion and currently holds the job title of supervisor and team leader. Petitioner testified that his current position does require him to continue to perform mechanics duties. Petitioner testified that his right knee continues to affect his ability to perform his work. Petitioner testified that climbing and descending ladders, as well as kneeling down continue to bother him. Petitioner testified that he continues to ice his knee and take ibuprofen after a full day of work. It is undisputed that Petitioner was off work from March 18, 2013 to May 5, 2014.

CONCLUSIONS OF LAW

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

The sole issue in dispute is the nature and extent of Petitioner's right knee injury. It is undisputed that Petitioner was diagnosed with traumatic right knee patellofemoral chondromalacia, right knee medial meniscus tear, right knee patellar tendinitis and tendinosis and right knee Hoffa's fat pad syndrome, which has left the Petitioner permanently partially disabled. Px1:60. Dr. Shah performed a partial medial meniscectomy, abrasion and arthroplasty of the patellofemoral joint and femoral trochlea, patellar tendon debridement, arthrotomy and excision of the Hoffa fat pad. *Id.* Petitioner averred he remains symptomatic and continues to suffer from pain, soreness and clicking in his right knee, in which additional injections were recommended. *Id.* at 105. Petitioner last saw Dr. Shah in August 2016 and was released to full duty work in May 2014. Petitioner has worked full duty since May 2014 and last treated with Dr. Shah in August 2016. Therefore, his claim for permanency, if any, is ripe for adjudication. In considering the required factors, the Arbitrator notes the following:

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the Petitioner was employed as a lineman/electrician at the time of the accident and that he is able to return to work in his prior capacity as a result of said injury. The Arbitrator notes that Petitioner testified credibly that he struggles to complete his duties due to right knee pain and weakness. The Arbitrator notes that Petitioner testified that he still struggles to bend his knee, kneel down, and climb and descend stairs and ladders. The Arbitrator notes that kneeling down and climbing stairs and ladders are part of Petitioner's job duties. The Arbitrator notes that the Petitioner testified that he completes his job duties more slowly and that he requests assistance from other workers more often. Because of heavy labor job duties and the fact that Petitioner

continues to have right knee pain and weakness while completing his job duties, which is corroborated by follow-up visits to his orthopedic physician and a full-duty release, the Arbitrator therefore gives *greater* weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was years old at the time of the accident, meaning he will continue to work with the effects of his injuries and may feel those effects to a greater degree than a younger person. In this regard, Petitioner's testimony as to those effects and difficulties were credible and bear out in his medical records. The Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that the Petitioner has maintained his earning capacity and the Arbitrator therefore gives *lesser* weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that the medical records corroborates the Petitioner's disability. Medical records include positive objective findings of structural damage, limited range of motion in Petitioner's right knee. Petitioner testified that he has marked deficit with respect to his right knee strength and motion. He also testified that his right knee affects the performance of his job duties and his activities of daily living. Petitioner also testified that he currently has difficulties performing current job duties that require physical work that includes kneeling and climbing stairs and ladders. He also testified that when he needs to perform physical work, he performs the work more slowly and often requires help from other employees. Petitioner testified that he continues to take medication after completing work throughout the week. Kneeling, climbing ladders and stairs, and bending his knee are all part of the full performance of Petitioner's job duties and the medical records accurately describe Petitioner's current functioning, limitations and disabilities. Petitioner's complaints, which highlight impaired motion and strength, are corroborated by medical records, which also noted that he was recommended for injections but those were never approved. The Arbitrator therefore gives *greatest* weight to this factor.

Based on the above factors and the record taken as a whole, the Arbitrator finds that Respondent shall pay Petitioner permanent partial disability benefits of **$712.55/week** for **54.825 weeks**, because the injuries sustained caused the **25.5%** loss of the **right leg**, as provided in Section **8(e)**.

Signature of Arbitrator

1-4-2017
Date

17IWCC0521

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

Maria Coates,

Petitioner,

vs.

NO: 15 WC 26789

17IWCC0522

Kindred Healthcare,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of accident, medical expenses, 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. 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 August 25, 2016, 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.

17IWCC0522

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 22 2017
TJT:yl
o 7/25/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

COATES, MARIA
Employee/Petitioner

Case# **15WC026789**

15WC026790

KINDRED HEALTHCARE
Employer/Respondent

17IWCC0522

On 8/25/2016, 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 0.45% 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
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

4876 ARNETT LAW GROUP
MONICA J KIEHL
500 W MONROE ST SUITE 2010
CHICAGO, IL 60661

17IWCC0522

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)

MARIA COATES,
Employee/Petitioner

v.

KINDRED HEALTHCARE,
Employer/Respondent

Case # **15** WC **26789**

Consolidated cases: **15 WC 26790**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **7/29/16**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On the date of accident, **7/28/15**, 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 **$26,034.32**; the average weekly wage was **$500.66**.

On the date of accident, Petitioner was **58** 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 **$00.00** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$00.00** for other benefits, for a total credit of **$00.00**.

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

ORDER

Respondent shall pay reasonable and necessary medical services related to petitioner's left knee from 7/28/15 through 7/29/16, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay all reasonable and necessary medical expenses related to the surgery recommended by Dr. Phillips, pursuant to Sections 8(a) and 8.2 of the Act.

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

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

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

Signature of Arbitrator

8/15/16
Date

ICArbDec19(b)

AUG 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

This case was heard in consolidation with case 15 WC 26790, which involves an accident to petitioner's left knee on 12/27/11. A separate decision was issued with respect to that matter.

Petitioner, a 58 year old unit secretary, alleges she sustained an accidental injury to his left knee on 7/28/15 that arose out of and in the course of her employment by respondent. Petitioner sustained a prior injury to her left knee on 12/27/11.

Petitioner has worked for respondent for about 6 years as a unit secretary and monitor tech. Petitioner's duties include sitting at the nurse's station and getting doctor's orders off the computer; sending out labs; handling doctor requests; and watching heart monitors. Petitioner does not have any direct patient care.

On 12/27/11 petitioner injured her left knee when she turned and twisted her left knee after standing up and pushing a chair out while responding to a patient call light. (15 WC 26790)

On 1/20/12 petitioner presented for treatment at IWIRC. She gave a consistent history of the injury. Petitioner's left knee was point tender medially but the pain radiated to the anterior aspect as well. She rated her pain at a 5-6/10. She described her symptoms as aching, radiating pain, occasional tingling, and swelling. Petitioner was examined and assessed with a left knee strain, and MCL strain. Petitioner was prescribed Naproxen, and a knee brace. She was given range of motion exercises. She was also released to regular duty work.

Petitioner followed up at IWIRC on 2/1/12, 2/15/12, and 2/29/12. On 2/15/12 petitioner was referred to physical therapy. She reported that her symptoms had been improving some. She stated that she was able to work throughout the day. She stated that her swelling had gone down and her pain had decreased to 2-3/10. Petitioner stated that she twisted her left knee a few days ago and had sharp pain that was now mild. Petitioner was examined and assessed with an improving left knee strain and MCL strain. On 2/29/12 petitioner reported that her symptoms had improved, but her left knee was sore on the medial side. She did not have any swelling. Overall her pain was improved. She rated her pain at a 4/10. Petitioner stated that she was having surgery soon. Petitioner was discharged from care.

On 8/14/12 petitioner presented to Dr. Dean Gravlin. She reported that she suffered a left knee injury at work when she got up to answer a warning buzzer and twisted her left knee. She reported immediate pain and swelling. She stated that she had undergone a course of physical therapy that entailed walking around. She complained of pain that it is aggravated if she goes up steps. She denied any

instability symptoms, such as locking or buckling. Dr. Gravlin assessed persistent left medial knee pain, and sprain versus internal derangement. Dr. Gravlin recommended resumption of formal physical therapy.

On 10/10/12 petitioner underwent an MRI of the left knee. The impression was mild diffuse free edge fibrilation of the medial meniscus without evidence of a frank meniscal tear; partial discoid configuration of the lateral meniscus without evidence of tear; mild to moderate diffuse chondromalacia patella; and large joint effusion and a minimal Baker's cyst. Also noted was a probable mild strain of the medial compartment.

On 12/18/12 petitioner presented to Dr. Mark Phillips on the referral of Dr. Gravlin. An examination revealed a nonspecific joint line tenderness on deep palpation with a rotational McMurray localization, much more positive on the left, negative on the right. He also noted a moderate Baker cyst and posterior effusion; minimal quadriceps insufficiency and no gait abnormality. Dr. Phillips was of the opinion that the MRI was questionable in regard to medial meniscus pathology and blunting. Dr. Phillips prescribed a course of physical therapy.

On 2/19/13 petitioner followed up with Dr. Phillips. She had increased mechanical symptoms, exquisite joint line tenderness and rotational localizations. She noted that she was not improved with conservative treatment. Surgical intervention was discussed.

On 4/5/13 petitioner underwent a left knee arthroscopy, partial medial and lateral meniscectomies, and excision of patellar plica. This procedure was performed by Dr. Phillips. Petitioner's post operative diagnosis was left knee medial and lateral meniscus tears, and left knee fibrotic prominent medial patellar plica.

Petitioner followed-up post operatively with Dr. Phillips on 6/5/13, 7/3/13, 8/28/13, 11/13/13, 2/5/14 and 4/2/14. On 8/28/13 petitioner still had some issues with medial discomfort and swelling. An injection was performed. On 11/13/13 Dr. Phillips noted that petitioner was doing well overall. He noted that petitioner had significant improvement with intermittent injections. Another injection was performed. On 2/5/14 petitioner reported that she was doing well and did not want an injection. On 4/2/14 petitioner had full range of motion and trace effusion. There was no evidence of infection. Petitioner underwent another injection. Dr. Phillips released petitioner on an as needed basis. He was of the opinion that petitioner had reached maximum medical improvement.

On 4/2/14 petitioner returned to work full duty and worked without incident, or any further treatment until 7/28/15.

On 7/28/15 petitioner alleges she sustained another injury to her left knee that arose out of and in the course of her employment by respondent. (15WC26789). While working on this day petitioner was called to the 3rd floor to get a CNA and go to the ICU to move a patient to the 3rd floor. The patient was to be brought upstairs in a big boy bed because he weighed over 300 pounds, and was on oxygen. Therefore, the oxygen tank was also on the bed.

Petitioner and the CNA first pushed the patient to the elevator. When the elevator opened the floor of the hallway and the floor of the elevator were uneven by about an inch. As petitioner was pushing the big boy bed with her hands, arms and knees in an effort to get it over the one inch gap between the floor and the elevator, her left knee was twisting and turning and she heard a pop in her left knee. The CNA was in the elevator pulling the big boy bed while petitioner was pushing the bed. Petitioner testified that she had pain while she was pushing, and there was a lot of pressure on her knee. After about 3-4 minutes petitioner and the CNA got the big boy bed in the elevator. Petitioner did not report the injury right away. Instead she went home and iced it and took some ibuprofen and Tylenol, like she did after she injured her left knee in 2011. Petitioner noticed some relief with the Tylenol.

Petitioner continued working for the rest of the week. During that time petitioner continued working, sitting, and taking orders off the fax machine. On 8/4/15 petitioner called respondent's 800 line and reported the injury on 7/28/15. Petitioner continued working.

On 8/4/15 petitioner signed an Application for Adjustment of Claim with respect to the injury on 12/27/11 when she was getting up from her desk to answer a patient light and injured her left knee. (15WC26790). The Application for Adjustment of Claim was filed on 8/8/15.

That same day petitioner signed an Application for Adjustment of Claim with respect to the alleged injury on 7/28/15 when she was moving a big boy bed and reinjured her left knee. (15WC26789). This Application for Adjustment of Claim was also filed on 8/8/15.

On 8/6/15 petitioner went to Unity Point for treatment. Petitioner gave a consistent history of the injury on 7/28/15. She reported that her pain was a constant ache. She rated her pain at 5/10. Left knee x-rays and an MRI of the left knee were prescribed.

On 8/7/15 petitioner underwent x-rays of the left knee. The impression was no acute changes.

On 8/13/15 Debbie Roberts, Director of Quality Management drafted a report. Roberts has worked for respondent for 4 1/2 years and worked with petitioner. She stated that on 8/4/15 she was at the 3rd floor nursing station reviewing patient labs from 10-11 am. She stated that petitioner was also at the nursing station. They were sitting next to each other and discussed labs. Roberts noted that petitioner did not mention injuring her knee to her, or her need to report the incident. She stated that when petitioner was up and walking around that day she did not notice a limp or hear petitioner complain of pain. Roberts noted that later that day petitioner called the triage line to report an injury. She also noted that petitioner had asked her supervisor for an incident report. Roberts noted that at no time was she notified of the injury on 8/4/15 or prior. Roberts noted that on 8/5/15 petitioner left a message on her phone regarding the injury.

When Roberts testified at trial she stated that she did not witness the injury on 7/28/15 and only worked with petitioner at the 3rd floor nursing station for an hour on 8/4/15. She stated that petitioner does not report to her and petitioner is not required to report any injury to her.

On 8/17/15 petitioner underwent an MRI of the left knee. The impression was abnormal appearance of the body and posterior horn of the medial meniscus; a suspected re-tear of the posterior horn, osteoarthritis with partial thickness cartilage thinning in all three compartments, but no full thickness cartilage defect.

On 9/23/15 petitioner returned to Dr. Phillips office and was seen by Lisa Friebohle, NP. Petitioner reported that she suffered a new injury at work on 7/28/15, when she was pushing a large bed with a patient on it from the first floor to the third floor. She stated that afterwards her left knee began aching and got progressively worse. She reported pain on the medial aspect of the knee and had increased pain with twisting. She also reported swelling at night. X-rays of the left knee were taken and Dr. Phillips reviewed the x-rays and MRI taken 8/17/15. Petitioner was diagnosed with a left knee traumatic medial meniscus tear. Dr. Phillips recommended a left knee arthroscopy, partial medial and/or partial lateral meniscectomy, and articular cartilage debridement. Petitioner was released to work on 10/10/15 and restricted to sedentary/sit down work with no lifting.

On 10/20/15 petitioner underwent a Section 12 examination performed by Dr. Troy Robert Karlsson, at the request of the respondent, regarding her injuries on 12/27/11 and 7/28/15. Petitioner gave a consistent history of the injuries and treatment to date. Petitioner complained of left knee pain on the inner side, which was different from what she had prior to the injury in 2015. She stated that her new

pain was more severe, and was at the posteromedial joint line. She stated that her knee pain is worse if she is sitting a lot, and better if she does a little bit of walking.

Dr. Karlsson performed a record review and physical examination. He was of the opinion that petitioner's x-rays from 2012 to 2015 clearly showed some mild arthritis which progressed to moderate arthritis over the years. He noted that the MRI in 2012 showed at most some fraying of the free edge of the meniscus with no frank tearing of the meniscus. He also noted that petitioner's later surgery in 2013, revealed significant tears of the medial and lateral menisci.

Dr. Karlsson was of the opinion that petitioner sustained a medial collateral ligament sprain as a result of her injury on 12/27/11, had treatment for this, and recovered by the end of February 2012. Dr. Karlsson was of the opinion that the significant meniscal tears on the medial and lateral menisci were likely degenerative in nature and not related to the 12/27/11 injury. He was of the opinion that the gap in treatment from 2/29/12 through 12/28/12 was significant, and the significant meniscal tears medially and laterally in early 2013 were unrelated to her injury on 12/27/11. He opined that petitioner's treatment up until 2/29/12 was related to the injury on 2/27/11, and treatment after that was not related. He recommended no further treatment for the 12/27/11 injury. He noted that petitioner had signs of progressive arthritis on her x-rays in 2012 to 2015. He agreed with the full duty release Dr. Phillips gave petitioner on 4/2/14. Dr. Karlsson opined that petitioner sustained an MCL sprain in December 2011 as evidenced by her physical exam, her MRI, and her drastic improvement over the next 2 months as would be expected with an isolated MCL injury. He then noted that she had a large gap in treatment in 2012, presented with symptoms consistent with a meniscal tear, and was found in 2013 to have medial and lateral meniscal tears. He was of the of the opinion that these were large tears and not something that would be missed on her prior MRI or physical exams.

With respect to the injury on 7/28/15 Dr. Karlsson opined that petitioner sustained a recurrent diagnosis of moderate osteoarthritis of the left knee, tricompartmental in nature, and possible recurrent medial meniscal tear. He opined that neither of these conditions are related to the 7/28/15 injury. He did not believe petitioner described a true injury of twist, turn or fall, but was simply pushing a heavy object on wheels. Dr. Karlsson opined that petitioner has degenerative osteoarthritis, but there may be a possibility of a degenerative recurrent meniscal tear as evidenced by the changes on the MRI. He was also of the opinion that the arthritis, seen on the petitioner's 2013 x-rays, was worse on the x-rays in 2015, when it was noted as being moderate in degree. He opined that if there is a meniscal tear present, it is a degenerative tear related to her arthritis. Dr. Karlsson did not review the MRI of October 2013. He

opined that treatment to date had been reasonable and necessary, but only the first 2 months of treatment at IWIRC are work related. He opined that surgery is a reasonable recommendation, but not related to a work injury. He believed petitioner was at MMI for her left knee with regards to the 2015 injury, and can work full duty without restrictions. Dr. Karlsson opined that petitioner has degenerative osteoarthritis in the knee which has been progressing over the last several years. He was of the opinion that petitioner had an MRI that confirmed these degenerative changes as well as changes in the meniscus, which could be completely related to her prior partial meniscectomy, or could be related to a new degenerative tear.

On 11/23/15 petitioner underwent a Section 12 examination by Dr. Lawrence Li at the request of petitioner. Petitioner provided a history of the accident on 11/27/11, the alleged injury on 7/28/15, and the treatment to date. Following an examination and record review, Dr. Li diagnosed a left knee medial meniscus tear. He opined that the December 2011 accident caused petitioner to suffer a medial and lateral meniscus tear, which Dr. Phillips diagnosed at the time of surgery. He opined that this injury was caused by the December 2011 injury. Dr. Li opined that the 7/28/15 injury caused further tearing in the medial meniscus. He opined that the tear in the medial meniscus is not a degenerative condition, and the tear in the medial meniscus was clearly extended (made larger), or caused by the 7/28/15 work injury. Dr. Li agreed with Dr. Phillips recommendation for the arthroscopic surgery because petitioner has a medial meniscus tear. Dr. Li opined that the injury petitioner described was definitely a mechanism which caused or made larger a medial meniscus tear. He opined that twisting the knee would get the meniscus caught and it would tear if it is caught and the knee is twisting. Dr. Li opined that all of petitioner's treatment for her left knee has been reasonable and necessary. Dr. Li opined that petitioner's complaints are consistent with the objective findings on the MRI of the medial meniscus tear. He noted that petitioner was tender over the posterior horn of the medial meniscus and also had a grossly positive medial McMurray test. Dr. Li was of the opinion that petitioner's physical examination and findings were consistent with the medial meniscus tear.

On 5/19/16 the evidence deposition of Dr. Li, an orthopedic surgeon, was taken on behalf of the petitioner. He opined that petitioner did not have full relief of her pain after the surgery in 2013, but that the injury on 7/28/15 caused her current condition and the need for surgery. He opined that all her treatment after 7/28/15 was reasonable and necessary. Dr. Li opined that the accident on 7/28/15 raised petitioner to a new level of symptoms.

On cross-examination Dr. Li opined that meniscus tears are never idiopathic in nature. He did not think menisci idiopathically tear.

On 6/6/16 the evidence deposition of Dr. Karlsson, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Karlsson was of the opinion that the degradation in petitioner's left knee in 2012 to 2013 was seen and an even greater change was seen from 2013 to 2015 on the x-rays. Dr. Karlsson opined that with arthritis one can have pain with just pushing a heavy object and get some temporary pain with that. However, he did not think that pushing a heavy object without a twist, sudden turn or a sudden loading would cause a meniscus tear. He noted that petitioner reported that after the 2015 injury her pain was on the inside of her knee, which was different from where it was after the 2011 injury. Dr. Karlsson noted that petitioner's records in late February of 2012, showed that she was nearly back to normal.

He opined that petitioner only sustained sprain of her medial collateral ligament in her left knee as a result of the accident on 12/27/11 and that the surgery in 2013 was not related to the injury on 12/27/11 because she had improved so much in the first 2 months and had an MRI that showed her meniscus was intact, and when she had surgery in 2013 she had significant changes in both the medial and lateral menisci tears, and that was a new pathology, or new diagnosis that came sometime after her improvement in February of 2012. He opined that with respect to the injury on 12/27/11 petitioner reached maximum medical improvement by 2/29/12 and was not in need of any restrictions.

After the injury on 7/28/15 Dr. Karlsson diagnosed moderate osteoarthritis of the left knee throughout all three compartments, and a possible recurrent medial meniscal tear. He opined that neither of these conditions were causally related to the accident on 7/28/15. At most, he opined that petitioner had a manifestation of symptoms from her preexisting arthritis as a result of the injury on 7/28/15. He opined that petitioner reached maximum medical improvement as a result of the injury on 7/28/15, and needs no further treatment. He did not believe any treatment petitioner received after 7/28/15 was causally related to the accident she sustained on 7/28/15. He opined that she could work without restrictions. Dr. Karlsson opined that the presence of arthritis makes an individual more likely to experience a meniscus tear.

On cross examination, Dr. Karlsson testified that he did not review any treating medical records after the injury on 7/28/15. He opined that doing something heavy can cause a temporary exacerbation or some temporary symptoms. He could not opine that petitioner did not need surgery for the condition of what he examined on 10/20/15.

With respect to the 12/27/11 injury petitioner did not have any scheduled follow-ups after her visit to IWIRC on 2/29/12. However, Dr. Karlsson agreed that petitioner was still sore on the medial side of the left knee. He noted that she stated that he symptoms were 90% improved. Dr. Karlsson did not review

any medical records for petitioner's between 2/29/12 and 10/10/12. Dr. Karlsson opined that the mechanism of injury on 12/27/11 is consistent with the kind of injury that would cause a meniscus tear because twisting was involved. Dr. Karlsson was under the opinion that petitioner had no symptoms in her left knee prior to 12/27/11.

C. DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT?

On 7/28/15 petitioner alleges that she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent. On that day petitioner was pushing a big boy bed holding a patient weighing over 300 pounds, across an uneven threshold between the floor and the elevator. The petitioner stated that while pushing the big boy bed with her hands, arms, and knees in an effort to get the big boy bed over the uneven threshold, her left knee twisted and turned while maneuvering the big boy bed, and then she heard a pop in her left knee. Petitioner experienced pain in her left knee and when she got home that night she iced it and took some ibuprofen and Tylenol, like she did after the injury on 12/27/11, in hopes that it would feel better.

Petitioner did not report the incident on 7/28/15 and continued working her regular duty job, which involved sitting at her desk working, or getting orders off the fax machine. However, when her left knee condition had not improved by 8/4/15 she called the respondent's 800 line and reported the injury on 7/28/15.

From 10-11 am on 8/4/15 Debbie Roberts, Director of Quality Management, was also working at the nursing station reviewing labs. She testified that petitioner did not report any injury to her. However, she also admitted that petitioner does not report to her, and would not be required to report any injury to her. Roberts testified that during the hour she was at the workstation with petitioner, she did not report any injury on 7/28/15, and she did not observe petitioner walking any different, nor did she observe petitioner to be in any pain. On 8/13/15 Roberts drafted a witness statement that essentially corroborated her testimony at trial.

On 8/6/15 petitioner sought treatment for her alleged injury at Unity Point. Petitioner gave a consistent history of the accident, and received treatment.

Respondent offered no other evidence to rebut the history of petitioner's incident on 7/28/15. Respondent did not call the CNA petitioner was working with when she had the alleged accident as a witness.

Based on the above, as well as the credible evidence, the arbitrator finds the petitioner has proven by a preponderance of the credible evidence, that she sustained an accidental injury to her left knee that arose out of and in the course of her employment by respondent on 7/28/15.

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

The parties stipulated that following the injury on 12/27/11 that petitioner's current condition of ill-being as it relates to her left knee was causally related to that injury through 4/2/14, and that all treatment petitioner received after the 12/27/11 through 4/2/14 was reasonable and necessary to cure or relieve petitioner from the effects of the injury on 12/27/11.

On 4/2/14 petitioner reported full range of motion and only trace effusion. There was no evidence of infection. Petitioner underwent another injection. Dr. Phillips released petitioner from his care at that time and released her on as needed basis. He noted that petitioner had reached maximum medical improvement.

Beginning on 4/2/14 petitioner worked her regular full duty job for respondent without any incident until the alleged injury on 7/28/15. During this period petitioner received no treatment for her left knee. Petitioner's first treatment after the injury on 7/28/15 was on 8/6/15 when she presented to Unity Point for care of her left knee. She provided a consistent history of the accident on 7/28/15, including the fact that while she was pushing the big boy bed with a 300 pound patient on it into the elevator, she was twisting and turning her hands, arms and legs in order to get the bed over the gap between the floor of the hallway and the elevator floor.

Petitioner had a repeat MRI of her left knee on 8/17/15. A suspected re-tear of the posterior horn, and osteoarthritis with partial thickness cartilage thinning in all 3 compartments of the knee was noted. No full thickness cartilage defect was noted. Petitioner stated that the pain after the 7/28/15 injury was different from the pain she had after the 12/27/11 accident.

Dr. Karlsson was of the opinion that petitioner's x-rays from 2012 to 2015 showed signs of progressive arthritis. He opined that with respect to the injury on 7/28/15 petitioner had a recurrent diagnosis of moderate osteoarthritis of the left knee, tricompartmental in nature, and possible recurrent medial meniscus tear, but that these conditions were not related to the accident on 7/28/15 because petitioner's injury did not include any twisting or turning, which is not accurate. He believed petitioner was only pushing and pulling the bed and this would not cause her current injuries. Dr. Karlsson also admitted that he did not review any of petitioner's treating medical records after the accident on 7/28/15.

The arbitrator gives little weight to the opinions of Dr. Karlsson based on the fact that he did not review petitioner's treating medical records after the 7/28/15 accident, and the fact that the credible evidence does show that petitioner was twisting and turning her left knee, and loading her left knee, while trying to get the big boy bed over the gap in the floor of the hallway and the floor of the elevator.

Another causal connection opinion was offered by Dr. Li. Dr. Li obtained an accident history from petitioner that described a twisting injury to her left knee on 7/28/15. He also performed a record review and an examination on 11/23/15. He opined that the injury on 7/28/15 caused further tearing in the medial meniscus, and that the medial meniscus tear was not a degenerative condition. He opined that after the 7/28/15 accident the tear in the medial meniscus was clearly extended (made larger), or the injury caused it. He opined that the injury petitioner described was definitely a mechanism which caused or made larger the medial meniscus tear. He opined that the twisting of the knee would get the meniscus caught and it would tear.

Based on the above, as well as the credible evidence, the arbitrator find the petitioner's current condition of ill-being as it relates to her left knee is casually related to the injury petitioner sustained on 7/28/15. The arbitrator bases this on the fact that the from 4/2/14 through 7/28/15 petitioner worked without incident and received no treatment for her left knee; that on 7/28/15 petitioner sustained a twisting injury to her left knee while trying to push a big boy bed holding a 300 pound patient over a gap between the floor of the hallway and the floor of the elevator; that after this injury petitioner has had ongoing symptomatology in her left knee that was different from after the 12/27/11 injury; and that the opinions of Dr. Li were more persuasive than those of Dr. Karlsson, especially given the fact that Dr. Karlsson admitted that he did not review petitioner's treating medical records after the injury on 7/28/15.

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 sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 7/28/15, and that petitioner's current condition of ill-being as it relates to her left knee is casually related to the injury petitioner sustained on 7/28/15, the arbitrator finds the treatment petitioner received for her left knee from 7/28/15 to 7/29/16 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 7/28/15. Respondent shall pay all reasonable and necessary medical expenses for petitioner's left knee from 7/28/15 through 7/29/16 pursuant to Section 8(a) and 8.2 of the Act. Respondent shall receive credit for all bills already paid.

K. IS PETITIONER ENTITLED TO ANY PROSPECTIVE MEDICAL CARE?

Having found petitioner sustained an accidental injury to his left knee that arose out of and in the course of his employment by respondent on 7/28/15, that petitioner's current condition of ill-being as it relates to her left knee is casually related to the injury petitioner sustained on 7/28/15, and that the treatment petitioner received for her left knee from 7/28/15 to 7/29/16 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 7/28/15, the arbitrator finds the left knee arthroscopy, partial medial and/or partial lateral meniscectomy, and articular cartilage debridement recommended by Dr. Phillips is reasonable and necessary to cure or relieve petitioner from the effects of the injury on 7/28/15. Respondent shall pay all reasonable and necessary medical expenses related to the surgery recommended by Dr. Phillips, pursuant to Sections 8(a) and 8.2 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

Maria Coates,

Petitioner,

vs.

NO: 15 WC 26790

17IWCC0523

Kindred Healthcare,

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petition for Review under §19(b) having been filed by the Respondent herein and notice given to all parties, the Commission, after considering the issues of medical expenses, permanent partial disability, 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.

Because this case was resolved with an award of permanent partial disability, it was not resolved under section 19(b) of the Act. The following sentence is excised from page 2 of the order: "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."

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed August 25, 2016, is hereby affirmed and adopted.

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

17IWCC0523

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 22 2017
TJT:yl
o 7/25/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

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

COATES, MARIA
Employee/Petitioner

Case# **15WC026790**

15WC026789

KINDRED HEALTHCARE
Employer/Respondent

17IWCC0523

On 8/25/2016, 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 o.45% 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 CHRIS DOSCOTCH
DAMON YOUNG
2708 N KNOXVILLE AVE
PEORIA, IL 61604

4876 ARNETT LAW GROUP
MONICA J KIEHL
500 W MONROE ST SUITE 2010
CHICAGO, IL 60661

17IWCC0523

STATE OF ILLINOIS)
)SS.
COUNTY OF MCLEAN)

- [ ] 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

MARIA COATES,
Employee/Petitioner

v.

KINDRED HEALTHCARE,
Employer/Respondent

Case # **15** WC **26790**

Consolidated cases: **15 WC 26789**

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Maureen Pulia**, Arbitrator of the Commission, in the city of **Bloomington**, on **7/29/16**. 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 _____

17IWCC0523

FINDINGS

On the date of accident, **12/27/11**, 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 on 12/27/11 through 4/2/14.

In the year preceding the injury, Petitioner earned **$26,034.32**; the average weekly wage was **$500.66**.

On the date of accident, Petitioner was **58** years of age, ***single*** with **0** dependent children.

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

Respondent shall be given a credit of **$3,268.98** for TTD, **$00.00** for TPD, **$00.00** for maintenance, and **$15,409.10** for other benefits, for a total credit of **$18,678.08**.

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

ORDER

Respondent shall pay reasonable and necessary medical services related to petitioner's left knee from 12/27/11 through 4/2/14, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall be given a credit for medical benefits that have been paid, and Respondent shall hold petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $300.40/week for 37.625 weeks, because the injuries sustained caused the 17.5% loss of the left knee, 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

8/15/16
Date

ICArbDec19(b)

AUG 25 2016

THE ARBITRATOR HEREBY MAKES THE FOLLOWING FINDINGS OF FACT:

This case was heard in consolidation with case 15 WC 26789, which involves an accident to petitioner's left knee on 7/28/15. A separate decision was issued with respect to that matter.

With respect to this matter, the parties stipulated on the Request for Hearing that petitioner's left knee condition as it relates to the injury on 12/27/11 is causally connected to the injury on 12/27/11 through 4/2/14. The parties further stipulated that the medical treatment petitioner received for her left knee after the 12/27/11 injury was reasonable and necessary to cure or relieve petitioner from the effects of her injury on 12/27/11 through 4/2/14.

Petitioner, a 58 year old unit secretary, sustained an accidental injury to her left knee on 12/27/11 that arose out of and in the course of her employment by respondent. Petitioner then sustained another injury to her left knee on 7/28/15. (15 WC 26789).

Petitioner has worked for respondent for about 6 years as a unit secretary and monitor tech. Petitioner's duties include sitting at the nurse's station and getting doctor's orders off the computer; sending out labs; handling doctor requests; and watching heart monitors. Petitioner does not have any direct patient care.

On 12/27/11 petitioner injured her left knee when she turned and twisted her left knee after standing up and pushing a chair out while responding to a patient call light. (15 WC 26790)

On 1/20/12 petitioner presented for treatment at IWIRC. She gave a consistent history of the injury. Petitioner's left knee was point tender medially but the pain radiated to the anterior aspect as well. She rated her pain at a 5-6/10. She described her symptoms as aching, radiating pain, occasional tingling, and swelling. Petitioner was examined and assessed with a left knee strain, and MCL strain. Petitioner was prescribed Naproxen, and a knee brace. She was given range of motion exercises. She was also released to regular duty work.

Petitioner followed up at IWIRC on 2/1/12, 2/15/12, and 2/29/12. On 2/15/12 petitioner was referred to physical therapy. She reported that her symptoms had been improving some. She stated that she was able to work throughout the day. She stated that her swelling had gone down and her pain had decreased to 2-3/10. Petitioner stated that she twisted her left knee a few days ago and had sharp pain that was now mild. Petitioner was examined and assessed with an improving left knee strain and MCL strain. On 2/29/12 petitioner reported that her symptoms had improved, but her left knee was sore on the

medial side. She did not have any swelling. Overall her pain was improved. She rated her pain at a 4/10. Petitioner stated that she was having surgery soon. Petitioner was discharged from care.

On 8/14/12 petitioner presented to Dr. Dean Gravlin. She reported that she suffered a left knee injury at work when she got up to answer a warning buzzer and twisted her left knee. She reported immediate pain and swelling. She stated that she had undergone a course of physical therapy that entailed walking around. She complained of pain that it is aggravated if she goes up steps. She denied any instability symptoms, such as locking or buckling. Dr. Gravlin assessed persistent left medial knee pain, and sprain versus internal derangement. Dr. Gravlin recommended resumption of formal physical therapy.

On 10/10/12 petitioner underwent an MRI of the left knee. The impression was mild diffuse free edge fibrilation of the medial meniscus without evidence of a frank meniscal tear; partial discoid configuration of the lateral meniscus without evidence of tear; mild to moderate diffuse chondromalacia patella; and large joint effusion and a minimal Baker's cyst. Also noted was a probable mild strain of the medial compartment.

On 12/18/12 petitioner presented to Dr. Mark Phillips on the referral of Dr. Gravlin. An examination revealed a nonspecific joint line tenderness on deep palpation with a rotational McMurray localization, much more positive on the left, negative on the right. He also noted a moderate Baker cyst and posterior effusion; minimal quadriceps insufficiency and no gait abnormality. Dr. Phillips was of the opinion that the MRI was questionable in regard to medial meniscus pathology and blunting. Dr. Phillips prescribed a course of physical therapy.

On 2/19/13 petitioner followed up with Dr. Phillips. She had increased mechanical symptoms, exquisite joint line tenderness and rotational localizations. She noted that she was not improved with conservative treatment. Surgical intervention was discussed.

On 4/5/13 petitioner underwent a left knee arthroscopy, partial medial and lateral meniscectomies, and excision of patellar plica. This procedure was performed by Dr. Phillips. Petitioner's post operative diagnosis was left knee medial and lateral meniscus tears, and left knee fibrotic prominent medial patellar plica.

Petitioner followed-up post operatively with Dr. Phillips on 6/5/13, 7/3/13, 8/28/13, 11/13/13, 2/5/14 and 4/2/14. On 8/28/13 petitioner still had some issues with medial discomfort and swelling. An injection was performed. On 11/13/13 Dr. Phillips noted that petitioner was doing well overall. He noted

that petitioner had significant improvement with intermittent injections. Another injection was performed. On 2/5/14 petitioner reported that she was doing well and did not want an injection. On 4/2/14 petitioner had full range of motion and trace effusion. There was no evidence of infection. Petitioner underwent another injection. Dr. Phillips released petitioner on an as needed basis. He was of the opinion that petitioner had reached maximum medical improvement.

On 4/2/14 petitioner returned to work full duty and worked without incident, or any further treatment until 7/28/15.

On 7/28/15 petitioner alleges she sustained another injury to her left knee that arose out of and in the course of her employment by respondent. (15WC26789). While working on this day petitioner was called to the 3rd floor to get a CNA and go to the ICU to move a patient to the 3rd floor. The patient was to be brought upstairs in a "big boy" bed because he weighed over 300 pounds, and was on oxygen. Therefore, the oxygen tank was also on the bed.

Petitioner and the CNA first pushed the patient to the elevator. When the elevator opened the floor of the hallway and the floor of the elevator were uneven by about an inch. As petitioner was pushing the big boy bed with her hands, arms and knees in an effort to get it over the one inch gap between the floor and the elevator, her left knee was twisting and turning and she heard a pop in her left knee. The CNA was in the elevator pulling the big buy bed while petitioner was pushing the bed. Petitioner testified that she had pain while she was pushing, and there was a lot of pressure on her left knee. After about 3-4 minutes petitioner and the CNA got the big boy bed in the elevator. Petitioner did not report the injury right away. Instead she went home and iced it and took some ibuprofen and Tylenol, like she did after she injured her left knee in 2011. Petitioner noticed some relief with the Tylenol.

Petitioner continued working for the rest of the week. During that time petitioner continued working, sitting, and taking orders off the fax machine. On 8/4/15 petitioner called respondent's 800 line and reported the injury on 7/28/15. Petitioner continued working.

On 8/4/15 petitioner signed an Application for Adjustment of Claim with respect to the injury on 12/27/11 when she was getting up from her desk to answer a patient light and injured her left knee. (15WC26790). The Application for Adjustment of Claim was filed on 8/8/15.

That same day petitioner signed an Application for Adjustment of Claim with respect to the alleged injury on 7/28/15 when she was moving a big boy bed and reinjured her left knee. (15WC26789). This Application for Adjustment of Claim was filed on 8/8/15.

On 8/6/15 petitioner went to Unity Point for treatment. Petitioner gave a consistent history of the injury on 7/28/15. She reported that her pain was a constant ache. She rated her pain at 5/10. Left knee x-rays and an MRI of the left knee were prescribed.

On 8/7/15 petitioner underwent x-rays of the left knee. The impression was no acute changes.

On 8/13/15 Debbie Roberts, Director of Quality Management drafted a report. Roberts has worked for respondent for 4 1/2 years and worked with petitioner. She stated that on 8/4/15 she was at the 3rd floor nursing station reviewing patient labs from 10-11 am. She stated that petitioner was also at the nursing station. They were sitting next to each other and discussed labs. Roberts noted that petitioner did not mention injuring her knee to her, or her need to report the incident. She stated that when petitioner was up and walking around that day she did not notice a limp or hear petitioner complain of pain. Roberts noted that later that day petitioner called the triage line to report an injury. She also noted that petitioner had asked her supervisor for an incident report. Roberts noted that at no time was she notified of the injury on 8/4/15 or prior. Roberts noted that on 8/5/15 petitioner left a message on her phone regarding the injury.

When Roberts testified at trial she stated that she did not witness the injury on 7/28/15 and only worked with petitioner at the 3rd floor nursing station for an hour on 8/4/15. She stated that petitioner does not report to her and petitioner is not required to report any injury to her.

On 8/17/15 petitioner underwent an MRI of the left knee. The impression was abnormal appearance of the body and posterior horn of the medial meniscus; a suspected re-tear of the posterior horn, osteoarthritis with partial thickness cartilage thinning in all three compartments, but no full thickness cartilage defect.

On 9/23/15 petitioner returned to Dr. Phillips office and was seen by Lisa Friebohle, NP. Petitioner reported that she suffered a new injury at work on 7/28/15, when she was pushing a large bed with a patient on it from the first floor to the third floor. She stated that afterwards her left knee began aching and got progressively worse. She reported pain on the medial aspect of the knee and had increased pain with twisting. She also reported swelling at night. X-rays of the left knee were taken and Dr. Phillips reviewed the x-rays and MRI taken 8/17/15. Petitioner was diagnosed with a left knee traumatic medial meniscus tear. Dr. Phillips recommended a left knee arthroscopy, partial medial and/or partial lateral meniscectomy, and articular cartilage debridement. Petitioner was released to work on 10/10/15 and restricted to sedentary/sit down work with no lifting.

On 10/20/15 petitioner underwent a Section 12 examination performed by Dr. Troy Robert Karlsson, at the request of the respondent, regarding her injuries on 12/27/11 and 7/28/15. Petitioner gave a consistent history of the injuries and treatment to date. Petitioner complained of left knee pain on the inner side, which was different from what she had prior to the injury in 2015. She stated that her new pain was more severe, and was at the posteromedial joint line. She stated that her left knee pain was worse if she is sitting a lot, and better if she was doing a little bit of walking.

Dr. Karlsson performed a record review and physical examination. He was of the opinion that petitioner's x-rays from 2012 to 2015 clearly showed some mild arthritis which progressed to moderate arthritis over the years. He noted that the MRI in 2012 showed at most some fraying of the free edge of the meniscus with no frank tearing of the meniscus. He also noted that petitioner's later surgery in 2013, revealed significant tears of the medial and lateral menisci.

Dr. Karlsson was of the opinion that petitioner sustained a medial collateral ligament sprain as a result of her injury on 12/27/11, and had treatment for this and recovered by the end of February 2012. Dr. Karlsson was of the opinion that the significant meniscal tears on the medial and lateral menisci were likely degenerative in nature and not related to the 12/27/11 injury. He was of the opinion that the gap in treatment from 2/29/12 through 12/28/12 was significant, and the significant meniscal tears medially and laterally in early 2013 were unrelated to her injury on 12/27/11. He opined that petitioner's treatment up until 2/29/12 was related to the injury on 2/27/11, and treatment after that was not related. He recommended no further treatment for the 12/27/11 injury. He noted that petitioner had signs of progressive arthritis on her x-rays in 2012 to 2015. He agreed with the full duty release Dr. Phillips gave petitioner on 4/2/14. Dr. Karlsson opined that petitioner sustained an MCL sprain in December 2011 as evidenced by her physical exam, and her MRI and her drastic improvement over the next 2 months as would be expected with an isolated MCL injury. He then noted that she had a large gap in treatment in 2012, presented with symptoms consistent with a meniscal tear, and was found in 2013 to have medial and lateral meniscal tears. He was of the of the opinion that these were large tears and not something that would be missed on her prior MRI or physical exams.

With respect to the injury on 7/28/15 Dr. Karlsson opined that petitioner sustained a recurrent diagnosis of moderate osteoarthritis of the left knee, tricompartmental in nature, and possible recurrent medial meniscal tear. He opined that neither of these conditions are related to the 7/28/15 injury. He did not believe petitioner described a true injury of twist, turn or fall, but was simply pushing a heavy object on wheels. Dr. Karlsson opined that petitioner has degenerative osteoarthritis, but there may be a

possibility of a degenerative recurrent meniscal tear as evidenced by the changes on the MRI. He was also of the opinion that the arthritis, seen on the petitioner's 2013 x-rays, was worse on the x-rays in 2015, when it was noted as being moderate in degree. He opined that if there is a meniscal tear present, it is a degenerative tear related to her arthritis. Dr. Karlsson did not review the MRI of October 2013. He opined that treatment to date has been reasonable and necessary, but only the first 2 months of treatment at IWIRC are work related. He opined that surgery is a reasonable recommendation, but not related to a work injury. He believed petitioner was at MMI for her left knee with regards to the 2015 injury, and can work full duty without restrictions. Dr. Karlsson opined that petitioner has degenerative osteoarthritis in the knee which has been progressing over the last several years. He was of the opinion that petitioner had an MRI that confirmed these degenerative changes as well as changes in the meniscus, which could be completely related to her prior partial meniscectomy or could be related to a new degenerative tear.

On 11/23/15 petitioner underwent a Section 12 examination by Dr. Lawrence Li at the request of petitioner. Petitioner provided a history of the accident on 11/27/11, the alleged injury on 7/28/15, and the treatment to date. Following an examination and record review, Dr. Li diagnosed a left knee medial meniscus tear. He opined that the December 2011 accident caused petitioner to suffer a medial and lateral meniscus tear, which Dr. Phillips diagnosed at the time of surgery. He opined that this injury was caused by the December 2011 injury. Dr. Li opined that the 7/28/15 injury caused further tearing in the medial meniscus. He opined that the tear in the medial meniscus is not a degenerative condition, and the tear in the medial meniscus was clearly extended (made larger), or caused by the 7/28/15 work injury. Dr. Li agreed with Dr. Phillips recommendation for the arthroscopic surgery because petitioner has a medial meniscus tear. Dr. Li opined that the injury petitioner described was definitely a mechanism which caused or made larger a medial meniscus tear. He opined that twisting the knee would get the meniscus caught, and it would tear if it is caught and the knee is twisting. Dr. Li opined that all of petitioner's treatment for her left knee has been reasonable and necessary. Dr. Li opined that petitioner's complaints are consistent with the objective findings on the MRI of the medial meniscus tear. He noted that petitioner was tender over the posterior horn of the medial meniscus and also had a grossly positive medial McMurray test. Dr. Li was of the opinion that petitioner's physical examination and findings were consistent with the medial meniscus tear.

On 5/19/16 the evidence deposition of Dr. Li, an orthopedic surgeon, was taken on behalf of the petitioner. He opined that petitioner did not have full relief of her pain after the surgery in 2013, but that the injury on 7/28/15 caused her current condition and the need for surgery. He opined that all her

treatment after 7/28/15 was reasonable and necessary. Dr. Li opined that the accident on 7/28/15 raised petitioner to a new level of symptoms.

On cross-examination Dr. Li opined that meniscus tears are never idiopathic in nature. He did not think menisci idiopathically tear.

On 6/6/16 the evidence deposition of Dr. Karlsson, an orthopedic surgeon, was taken on behalf of the respondent. Dr. Karlsson was of the opinion that the degradation in petitioner's left knee in 2012 to 2013 was seen and an even greater change was seen from 2013 to 2015 on the x-rays. Dr. Karlsson opined that with arthritis one can have pain with just pushing a heavy object and get some temporary pain with that. However, he did not think that pushing a heavy object without a twist, sudden turn or a sudden loading would cause a meniscus tear. He noted that petitioner reported that after the 2015 injury her pain was on the inside of her knee, which was different from where it was after the 2011 injury. Dr. Karlsson noted that petitioner's records in late February of 2012, showed that she was nearly back to normal.

He opined that petitioner only sustained a sprain of her medial collateral ligament in her left knee as a result of the accident on 12/27/11 and that the surgery in 2013 was not related to the injury on 12/27/11 because she had improved so much in the first 2 months and had an MRI that showed her meniscus was intact, and when she had surgery in 2013 she had significant changes in both the medial and lateral menisci tears, and that was a new pathology, or new diagnosis that came sometime after her improvement in February of 2012. He opined that with respect to the injury on 12/27/11 petitioner reached maximum medical improvement by 2/29/12 and was not in need of any restrictions.

After the injury on 7/28/15 Dr. Karlsson diagnosed moderate osteoarthritis of the left knee throughout all three compartments, and a possible recurrent medial meniscal tear. He opined that neither of these conditions were causally related to the accident on 7/28/15. At most he opined that petitioner had a manifestation of symptoms from her preexisting arthritis as a result of the injury on 7/28/15. He opined that petitioner reached maximum medical improvement as a result of the injury on 7/28/15, and needs no further treatment. He did not believe any treatment petitioner received after 7/28/15 was causally related to the accident she sustained on 7/28/15. He opined that she could work without restrictions. Dr. Karlsson opined that the presence of arthritis makes an individual more likely to experience a meniscus tear.

On cross examination Dr. Karlsson testified that he did not review any treating medical records after the injury on 7/28/15. He opined that doing something heavy can cause a temporary exacerbation or

some temporary symptoms. He could not opine that petitioner did not need surgery for the condition of what he examined on 10/20/15.

With respect to the 12/27/11 injury petitioner did not have any scheduled follow-ups after her visit to IWIRC on 2/29/12. However, Dr. Karlsson agreed that petitioner was still sore on the medial side of the left knee. He noted that she stated that he symptoms were 90% improved. Dr. Karlsson did not review any medical records for petitioner between 2/29/12 and 10/10/12. Dr. Karlsson opined that the mechanism of injury on 12/27/11 is consistent with the kind of injury that would cause a meniscus tear because twisting was involved. Dr. Karlsson was under the opinion that petitioner had no symptoms in her left knee prior to 12/27/11.

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

The respondent claims that following the injury on 12/27/11 that petitioner's current condition of ill-being as it relates to her left knee was causally related to that injury through 4/2/14. On 4/2/14 petitioner reported full range of motion and only trace effusion. There was no evidence of infection. Petitioner underwent another injection. Dr. Phillips had released petitioner from his care at that time and released her on as needed basis. He noted that petitioner had reached maximum medical improvement.

Beginning on 4/2/14 petitioner worked her regular full duty job for respondent without any incident until the alleged injury on 7/28/15. During this period petitioner received no treatment for her left knee.

Based on the above as well as the credible evidence the arbitrator finds the petitioner's current condition of ill-being as it relates to her left knee is causally related to the injury she sustained on 12/27/11 through 4/2/14, the date Dr. Phillips released petitioner from his care and was of the opinion that she had released maximum medical improvement.

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 that petitioner's current condition of ill-being as it relates to her left knee is casually related to the injury petitioner sustained on 12/27/11 through 4/2/14, the arbitrator finds the medical treatment petitioner received for her left knee from 12/27/11 to 4/2/14 was reasonable and necessary to cure or relieve petitioner from the effects of the injury she sustained on 12/27/11. Given respondent's stipulation on the Request for Hearing that all medical treatment for petitioner's left knee from 12/27/11 through 4/2/14 was reasonable and necessary to cure or relieve petitioner from the effects of the injury on 12/27/11, the arbitrator finds respondent shall pay all reasonable and necessary medical expenses for

petitioner's left knee from 12/27/11 through 4/2/14 pursuant to Section 8(a) and 8.2 of the Act. Respondent shall receive credit for all medical bills already paid.

K. WHAT IS THE NATURE AND EXTENT OF THE INJURY?

As a result of the injury to her left knee on 12/27/11, petitioner initially underwent conservative treatment. When this treatment did not fully alleviate petitioner's symptomatology petitioner underwent a left knee arthroscopy, partial medial and lateral menisectomies, and excision of the patellar plica. Petitioner followed up post-operatively with Dr. Phillips until 4/2/14, at which time Dr. Phillips released petitioner from his care and was of the opinion petitioner had reached maximum medical improvement.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. The Arbitrator therefore gives no weight to this factor.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a unit secretary at the time of the accident and was able to return to work on 4/2/14 in her prior capacity as a result of said injury. The Arbitrator notes that following her release from care by Dr. Phillips on 4/2/14, petitioner worked her regular duty job without incident and did not require any further medical treatment until she sustained a subsequent unrelated injury to her left knee on 7/28/15. Because petitioner was able to return to her full duty job, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 58 years old at the time of the accident. Because petitioner was able to return to her regular job and worked without incident until an unrelated incident on 7/28/15, the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that after petitioner returned to work she continued earning the same wages until her subsequent unrelated injury on 7/28/15. Because of this the Arbitrator therefore gives lesser weight to this factor.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that on 4/2/14, when petitioner last followed-up with Dr. Phillips, she had full range of motion and trace effusion. There was no evidence of infection. Petitioner underwent another injection. Dr. Phillips released petitioner on an as needed basis. He was of the opinion that petitioner had reached maximum medical improvement. Petitioner sought no further

treatment until her unrelated injury on 7/28/15. Because petitioner was not symptom free on 4/2/14 and had to undergo another injection, the Arbitrator therefore gives greater weight to this factor.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 17.5% loss of use of left knee pursuant to §8(e) of the Act.

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 MADISON)	☐ Reverse	☐ Second Injury Fund (§8(e)18)
		☐ PTD/Fatal denied
	☐ Modify	☒ None of the above

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Brian Oster,

Petitioner,

vs. NO: 11 WC 19246

17IWCC0524

Power Maintenance & Constructors,

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 August 31, 2016, is hereby affirmed and adopted.

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

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

17IWCC0524

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $52,800.00. The party commencing the proceedings for review in the Circuit Court shall file with the Commission a Notice of Intent to File for Review in Circuit Court.

DATED: AUG 22 2017
TJT:yl
o 8/15/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

OSTER, BRIAN
Employee/Petitioner

Case# **11WC019246**

POWER MAINTENANCE & CONTRUCTORS
Employer/Respondent

17IWCC0524

On 8/31/2016, 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 0.48% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

4364 LAW OFFICE OF THOMAS SCHOOLEY
2038 EDISON AVE
PO BOX 1289
GRANITE CITY, IL 62040

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

17IWCC0524

STATE OF ILLINOIS)
)SS.
COUNTY OF Madison)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Brian Oster
Employee/Petitioner

v.

Power Maintenance & Constructors
Employer/Respondent

Case # 11 WC 19246

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 **Melinda Rowe-Sullivan**, Arbitrator of the Commission, in the city of **Collinsville**, on **June 28, 2016**. 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. [x] Other **Mileage**

FINDINGS

On **March 21, 2011**, Respondent *was* operating under and subject to the provisions of the Act.

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

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

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

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

In the year preceding the injury, per the stipulation of the parties, Petitioner earned an average weekly wage of **$1,473.20**.

On the date of accident, Petitioner was **49** years of age, ***single*** with **1** dependent child.

The parties stipulated at the time of hearing that Respondent paid **$0** in TTD, **$0** in TPD, **$0** in maintenance, **$0** in non-occupational indemnity disability benefits, and **$0** in other benefits, for which credit may be allowed under Section 8(j) of the Act.

ORDER

Respondent shall pay **for medical services in the amount of $27,622.27 (*i.e.*, medical bills as contained in Petitioner's Exhibit 2)** as provided in Sections 8(a) and 8.2 of the Act. Respondent is to hold Petitioner harmless for any claims for reimbursement from any health insurance provider and shall provide payment information to Petitioner relative to any credit due. Respondent is to pay unpaid balances with regard to said medical expenses directly to the providers. Respondent shall pay any unpaid, related medical expenses according to the fee schedule and shall provide documentation with regard to said fee schedule payment calculations to Petitioner.

Respondent shall pay Petitioner temporary total disability benefits of **$982.13**/week for **3 4/7 weeks** for the timeframe of **April 19, 2012 through May 13, 2012**, as provided in Section 8(b) of the Act.

Respondent shall pay Petitioner the sum of **$669.64/week** for a further period of **32.25 weeks**, as provided in Section 8(e) of the Act, because the injuries caused **15% loss of use of the right leg.**

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.

Melinda M. Gore-Sullivan

Signature of Arbitrator

8/26/16

Date

AUG 31 2016

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

17IWCC0524

Brian Oster
Employee/Petitioner

Case # 11 WC 19246

v.

Consolidated cases: N/A

Power Maintenance & Constructors
Employer/Respondent

MEMORANDUM OF DECISION OF ARBITRATOR

FINDINGS OF FACT

Petitioner testified that he is a union electrician and works out of Local Union 1 in St. Louis. He testified that he has been a Union 1 electrician since 1996, and that at the times when he becomes unemployed, he goes through the hiring hall. He testified that depending on the job and the nature of the work, the jobs can last various lengths of time. He testified that he mainly does industrial or commercial work, and that he installs conduit, electrical equipment, devices, wiring and does all phases of new construction and retro fit.

Petitioner testified that prior to March 21, 2011, he did not have any issues with regard to his right leg or knee. He also denied ever having seen any doctors before March 21, 2011 for any right leg or knee issues or symptomatology.

Petitioner testified that on March 21, 2011, he was working for PMC (Power Maintenance Contractors) at the Ballwin Powerhouse. He testified that he believed that he had started there the prior September or October of 2010. He testified that they were installing a scrubber unit that basically cleansed the emissions of the powerhouse. He testified that his duties included installing conduit, pulling wire, terminating the wire and prepping material for different projects.

Petitioner testified that in the 6-7 months prior to March 21st, he was able to perform his duties as a construction electrician without any physical restrictions or restraints as it pertains to his right knee. He denied having any symptoms whatsoever in his right leg or knee as he was working leading up to March 21, 2011.

Petitioner testified that a trapeze is a piece of unit strut approximately 40 inches long, with sections of all thread that run vertically up to another section of the unit strut that attaches to the cable tray and that the conduit rests on the lower unit strut. He testified that supports are installed and could be angled steel or could be also a unit strut attached by spring nuts to the unit strut and locked down with a lock nut. He testified that the trapeze is the support for the conduit and/or the electrical wiring.

Petitioner testified that on March 21, 2011, he and another wire man, Tyson Fifer, were tasked to prefabricate several trapeze for the upcoming project. He testified that they had pretty much finished all the trapeze and had set them aside, but that they then we wanted to move them so they picked them up and carried them to a different area to get them out of the way of any lifts. He testified that he and Mr. Fifer had fabricated 20-25 trapeze that morning before they started the process of transporting them. He

testified that he had picked up three and had taken them around and set them down and that he had made several trips. He testified that on one trip, he and Mr. Fifer were heading towards each other, so he walked around him. He testified that when he did that, he stepped off in a hole or a gravel depression shaped like a bowl that was approximately 3.5-4 feet wide and 6-8 inches deep and was sloped on the sides like a bowl.

Petitioner testified that each trapeze weighed 20-25 pounds, and that at the time that he stepped into the hole, he was carrying three. He testified that he was carrying 60-75 pounds at the time. He testified that the area that he had to walk across when he was carrying the trapeze was a gravel road where a lot of foot traffic, heavy equipment and vehicular traffic caused the water that had been standing in them to splash out. He testified that the path that he took on the previous several trips was the most efficient way to get the work from where he fabricated it to where he was supposed to put it.

Petitioner testified that when he stepped in the hole and that he felt a pop and a sharp, shooting pain on the outside of his knee. He testified that he did not fall to the ground, but that he stumbled and caught himself. He testified that immediately after this occurred, his foreman, Travis Webb, was walking down the road toward them at the time and that he informed him of what had just happened. He testified that he and Webb walked to the administration trailer where the safety personnel were. He testified that he just set the trapeze down that he had been carrying down and that he was not able to carry them to the final spot where they were supposed to go.

Petitioner testified that Mr. Webb was his foreman. He testified that he was maybe 100 yards down the road walking towards him, and that after he stepped in the hole, he continued walking up to him. He testified that he told Mr. Webb that he had slipped in the hole and either twisted his knee or popped something. He testified that he was not immediately next to the hole at the time that he talked to him, and that he had walked out into more of the road to meet him when he walked up. He testified that he showed Mr. Webb exactly where he had slipped into the hole. When asked if Mr. Webb had any reaction when he showed him the area of the hole that he stepped in, he responded that Mr. Webb was more concerned about getting to the safety trailer and filing the report. He testified that he and Mr. Webb then went to the safety trailer, where they filed an accident report with the safety personnel on duty. He testified that the accident occurred at the end of the day at 3:10-3:15.

Petitioner testified that he recalled being examined by a physician for an independent medical examination by Dr. Williams. He testified that when he saw Dr. Williams, he had photographs for him to look at. He testified that when Dr. Williams showed him the photograph and asked him if this was the hole that he had stepped in, he told him that there were a lot of holes in the area and that he could not be certain that was the exact one. He testified that he did notice that the pictures he showed him were different in contrast than the actual area. He testified that the photos he looked at showed that the actual hole appeared to be filled in with a clean 1-inch rock and had not been traversed by anyone.

Petitioner testified that the photos that he saw at Dr. Williams' office were color and that they showed the contrast better than the black and white photos. He testified that he was not certain if Respondent's Group Exhibit 1 were the photographs that he would have looked at at Dr. Williams' office on the date of the examination.

Petitioner testified that he continued working the next couple days before he sought medical care and treatment. He testified that the outside of the knee was tender, and that if he exerted himself either by climbing ladders or stairs it would swell. He testified that a few days later he had decided that it was getting worse and needed to get it looked at. He agreed that he saw Dr. Byler on March 24, 2011 and that he examined the area, gave him a drug test, gave him a knee support to wear and suggested icing the knee

and propping it up. He testified that he also had an x-ray at Belleville Memorial, which did not reveal a fracture. He testified that the pain was on the back outside of his right knee.

Petitioner testified that Dr. Byler did not take him off work, and that he followed up with him on April 8, 2011 and told him that he thought that the popping had gotten better and that there had been no locking, catching or giving out. He testified that he next saw Dr. Byler on April 21st because he was having some issues and was not getting any better, and that Dr. Byler said he needed to get an MRI which was performed on April 27, 2011.

Petitioner testified that he saw Dr. Byler on April 29th, at which time he reviewed the MRI and told him he should see an orthopedic surgeon. He testified that he saw Dr. George Paletta on May 13, 2011, and that he had pain on the outside or lateral part of his right knee. He testified that Dr. Paletta wanted him to ice it, prop it up and continue to wear his knee support. He testified that he also thought that it would require surgery. He testified that he then saw Dr. Williams on September 20, 2011, and that his surgery was not approved. He testified that he eventually went ahead and had the surgery performed by Dr. Paletta on April 19, 2012.

Petitioner testified that during the timeframe between when he first saw Dr. Paletta and before he had surgery, he did not re-injure or aggravate his right knee. He testified that he had the same continued symptomatology that he had after he first saw Dr. Paletta. He testified that after surgery, he had physical therapy and that Dr. Paletta had him off work from April 16, 2012 to May 14, 2012. He denied receiving any workers' compensation benefits for that period of time.

Petitioner testified that the last time he saw Dr. Paletta was on June 18, 2012, when it was noted that he had some occasional discomfort and had returned to work but there had not been much work available. He testified that he was placed at maximum medical improvement at the last visit and was told to come back if needed. He agreed that he has not seen Dr. Paletta since.

Petitioner testified that as long as he does not excessively use his knee like climbing ladders or stairs all day then his knee is fine but if he does, then his knee stays swollen for a week at a time. He testified that he has pain any time he is tasked to perform extensive ladder work or a lot of stairs. He testified that ladder work was pretty much a daily part of his job but how much could vary, and that once a month it would flare up and swell. He testified that when it flares he takes over-the-counter Ibuprofen, and that it can take up to a week for the swelling to go down. He testified that his pain is a 4-5/10.

Petitioner testified that he has not lost any time from work due to the knee problem since being returned to work by Dr. Paletta, and he further denied turning down any jobs. He testified that when he attempts to squat with both legs, he does not have full range of motion and can only go down so far. He testified that he has out-of-pocket expenses that were primarily for Dr. Paletta's office visits and that he also had a large amount the day of the surgery. He testified that he paid that on a credit card as they would not do the surgery without pre-payment.

Petitioner testified that the mileage between his house and Dr. Paletta's office was 77 miles each way and that he made four visits to Dr. Paletta, which included the surgery. He testified that it was 84 miles one way to the Imaging Center where he had his MRI, and that his physical therapy was performed in his home town of Farmington which was a 10-mile round trip for the 10 visits of therapy.

On cross examination, Petitioner agreed that his physical therapy was located locally near his home, and that there used to be two hospitals near his home but that now there was just one. He testified that at the time he was getting treatment there were two hospitals. He testified that he did not know if they had MRI facilities and admitted that he did not check, and testified that either Dr. Paletta or Dr.

Byler suggested he go to the Imaging Center. He agreed that it was possible there was an MRI facility associated with one of the hospitals in his location, and that he went where Dr. Paletta told him to go.

On cross examination, Petitioner agreed that there were also orthopedic doctors in his hometown. He testified that he went to see Dr. Paletta because he was renowned as a very good doctor in the area. He testified that he had mentioned the injury to some "medical people" in his home area, and that they knew he had done work on the Cardinals and the Blues so he wanted to get to the best place he could. He further testified that the names of the two hospitals in his location at the time he was treating were Mineral Area Osteopathic Hospital and Farmington Community Hospital.

On cross examination, Petitioner agreed that he testified that if he uses his knee excessively, it will swell. He testified that he has not returned to Dr. Paletta since he was released to return to work. He denied having seen any other orthopedic doctor for his right knee since he was released by Dr. Paletta. He testified that he continues to do the same category of job that he did before the incident.

On cross examination, Petitioner agreed that everyone has a different interpretation of what a "hole" means. He agreed that the definition included the words, pit, cavity, crater, depression and indentation, and that those words could also be used in place of the word "hole". He testified that the pictures of the depression that he was shown by his attorney were not as deep as it was when he stepped in it. He testified that the pictures were very vague and that the clarity was lost, and that the ones that he saw at Dr. Williams' office were much clearer. He testified that he was unable to agree that the item shown on the first page of Respondent's Group Exhibit 1 could be considered a depression. He testified that he could not see a depression on page 5 of Respondent's Group Exhibit 1.

On cross examination, Petitioner agreed that the area that he walked into was 6-8 inches deep. He agreed that not everything that was 6-8 inches deep was a hole. He agreed that the item shown in Respondent's Group Exhibit 1 was, by his definition, not a hole, and that one of the reasons he would say it was not a hole was because it was less than two inches deep. He agreed that the item shown in Respondent's Group Exhibit 1 was an area that had a difference in grade from absolutely level. He testified that there were potholes, depressions, craters, holes and the like around the gravel area where water had been standing and had been splashed out. He agreed that differences in grade were common on any work site.

On cross examination, Petitioner agreed people walk through differences in grade all the time in the outside world. He agreed that if it did not have water accumulating in it, people could walk through them as they did in any parking lot. He agreed that the differences in grade as shown in Respondent's Group Exhibit 1 were found everywhere in the outside world. He agreed that when he was working on this site and observed the gravel that was on the ground, he was not expecting that site to be absolutely level like the ice the St. Louis Blues play on. He agreed that it was not a concrete surface. He agreed that from his estimation, there was a difference in contrast between the rock that was in the depression and the surrounding area on the photo. When asked if he had any knowledge when that rock was placed in that general area or why that rock was placed there, he responded that he had no knowledge and that it was not there the day he stepped into the crater or hole.

On cross examination, Petitioner testified that he did not know what was located underground beneath the surface of the crater. He testified that he is 6'2" and weighs approximately 300 pounds and that he weighed about the same at the time of the accident.

On cross examination, Petitioner testified that he had no idea whether Dr. Williams received the photos in a digital form and then printed them onto a color printer. He testified that he felt that they were original pictures, but admitted that he could not be certain. He testified that he looked at photographs, not

something that had been printed on a piece of paper.

On redirect examination, Petitioner testified that it was his understanding that Dr. Byler ordered the MRI.

Keith Vidal was called as a witness by Respondent at the time of arbitration. He testified that he is a consulting safety engineer and did standards development work. He testified that he has a Bachelor of Science in mechanical engineering from the University of Nebraska and also has a Master of Science also in mechanical engineering from the University of Nebraska. He confirmed that his curriculum vitae, Respondent's Exhibit 2, is correct and up-to-date and contains his background regarding his experiences in mechanical engineering and construction engineering, as well as his presentations or publications in that area.

Mr. Vidal testified that he has experience in assessing the safety of construction sites, and that he was given the opportunity to look at pictures included within Respondent's Group Exhibit 1. He testified that he was asked to reach a conclusion regarding whether the area that is depicted in Respondent's Group Exhibit 1 would be considered a defect on a construction site. He testified that his conclusion was that that kind of a change in elevation or a slope in such an area would not be considered a defect. He testified that in his field of expertise and his experience of going on construction sites, he commonly saw differences in grade like those as depicted in Respondent's Group Exhibit. 1. He testified that generally, construction workers become used to their environment, that in a construction area there are many changes in elevation as people walk around and work, and that you have an expectation to adapt to that environment.

Mr. Vidal testified that generally, as humans, we have expectations that when we walk on a flat, level surface, we expect it to be a flat and level surface for the most part and that there will be a small change in elevation for things like thresholds in door areas. He testified that on surfaces where you have rock, mud, trails or mulch, those are surfaces where you do have variations and that those kinds of things are environments where you walk into them, you take notice and you get used to it, and that you essentially compensate for it in the way you work around it.

Mr. Vidal testified that based on the photographs, it was his understanding many of the photographs depicted what was commonly referred to as 6-foot level, and that it had essentially been placed over a depressed gravel area. He testified that with scale, it was just about over three feet. He testified that there was 1½ inches in about 36 inches of run, so it was about a ½ of an inch for every 12 inches which was half of the slope that would be allowable for a disabled ramp under the ADA.

Mr. Vidal testified that he saw evidence of grade differences out in the parking lot of the Herrin arbitration hearing site. He testified that just because something was not completely flat did not mean that it was defective. He testified that he did not consider the depressed area depicted in Respondent's Group Exhibit 1 to be a defect.

On cross examination, Mr. Vidal agreed that his opinions were based on the pictures contained in Respondent's Group Exhibit No. 1. He denied looking at any other material from the job site or any other thing relative to this incident. He agreed that if what was contained in Respondent's Group Exhibit 1 was not actually the depicted site as it was when Petitioner stepped in it, his opinions could change.

On cross examination, Mr. Vidal testified that he opened his file in April of 2012. He agreed that if the accident happened in March of 2011, he was contacted over a year post-accident. He agreed that he did not go to the job site. He agreed that he did not review the surrounding area. He further agreed that

the only basis upon which he has given his opinions are the photographs contained in Respondent's Group Exhibit 1.

On cross examination, Mr. Vidal testified that he did not review any witness statements. He testified that all he did was take a look at the photographs with scales in them so he could get some dimensions, and that from those he could tell what kind of slope was involved. He agreed that based on the photographs, there was no defect. He agreed that employees in the construction field sometimes were required to encounter those hazards as part of their employment, but that the depression in this case was a subtle slope and that certainly would not consider that to be a hazardous condition.

On cross examination, Mr. Vidal agreed that there was no need to backfill or put any gravel in a depression that was less than 2 inches, but that it was job dependent. He testified that the change in elevation over the width was what came into the slope calculation, so depending on the depth it may require some action to be taken. He testified that if the hole exists 3 1/2 foot by 4 foot and 6 to 8 inches deep in an area that is traversed by employees, he would be more concerned about a depression that was that deep as opposed to what was documented in the pictures. He agreed that a proper remedy would be to backfill it to get it to the proper level seen in Exhibit 1. He further agreed that if it was creating a problem for people to do their job, including carrying loads, and they could not get around it appropriately, it might be of concern.

On redirect examination, Mr. Vidal testified that if you had an area of about 4 feet across and about 6 inches deep, it would be approximately 4 times as excessive as what the ADA would require. He agreed, however, that the pictures in Group Exhibit 1 would be more than compatible with the ADA.

John Bush was called as a witness by Respondent at the time of arbitration. Mr. Bush testified that he works for Hayes Mechanical, but that he worked for Respondent on March 21, 2011. He testified that he was at the Ballwin construction site and that he was a safety manager. He testified that he became aware of an incident wherein Petitioner claimed to have injured his knee, and that Petitioner and his foreman came to his office to report it.

Mr. Bush testified that after he learned of the incident, they checked Petitioner out to see if he needed any medical attention at that time and that as he remembered, Petitioner did not ask for any medical attention at that time. He testified that they filled out a report and that it was late in the afternoon around 2:30, so they filled out the accident report the next day. He testified that he took pictures of the area in which Petitioner claims claimed to have traveled when he experienced the incident.

Mr. Bush testified that Respondent's Group Exhibit 1 were the pictures that he took, and that Travis Webb, Petitioner's foreman, took him to that spot as Petitioner pointed it out as the area where he allegedly had the knee injury. He testified that he had opportunity to see the location where the incident took place on March 22nd, the next day. He testified that they walked up to the area and that it was near the Unit 1 overhead door. He testified that they had been fabricating material to install cable tray above the transformers in that location. He testified that he walked right up to within a couple of feet of the area when he saw it. He testified that he thought the pictures were taken a few days afterwards. He testified that there did not appear to be any difference between what was depicted in those pictures and what he saw the next day on March 22, 2011.

Mr. Bush testified that there was a pipe installed under the area featured in the picture, and that this would explain why there was a difference in rock in that area as opposed to the surrounding area. He testified that he had seen grade variations like that in other parts of the construction site, and that he has seen such grade variations in other construction sites that he has been on. He also testified that he has seen such grade variations in the "outside world" as well.

On cross examination, Mr. Bush agreed that the photographs depicted in Respondent's Group Exhibit 1 were taken a few days after the 22nd. He testified that he did not know which day of the week they were taken as he did not have a calendar. He testified that he took the photographs. He testified that he recognized the document titled "Power Maintenance & Constructors" (*i.e.*, Petitioner's Exhibit 6) and that it contained some daily notes that he took. He testified that they correctly and accurately reflected his thoughts and impressions with regard to what occurred on March 21st, March 22nd, and March 23rd, 2011 with regard to Petitioner and his incident.

On cross examination, Mr. Bush agreed that there was expert testimony that there would be no need to put in any gravel to alleviate the depression, which was shown to be less than 2 inches. He testified that he contemplated putting gravel into the area and that he noted that he asked laborers to bring a shovel and to fill the hole in. He agreed that the hole he was referring to was the hole that he was shown by Travis Webb as to where Petitioner fell. He denied that the hole was 6-8 inches deep. He agreed that Mr. Webb's response was that there were areas all over the job site that were similar to this area, and that you could not make it perfect for everyone.

On cross examination, Mr. Bush testified that he did not believe anyone placed any material into the area depicted in Respondent's Group Exhibit 1 because he viewed it before, during and after, and that he did not notice any difference. When asked what happened to his request on March 22nd that the laborers go get shovels and fill the hole, he responded that he was told that if they went to filling every hole like this on the job site, they would be there for weeks doing that because it was like that everywhere.

On cross examination, Mr. Bush testified that the pipe that he was referring to was installed months before the accident and that a different company put it in. He agreed that it could have been before Respondent came on the project, but that he did not know if it was sometime prior to September of 2010. He testified that he did not know how deep the pipes were. He agreed that when the pipes were installed, the area had to be excavated and that once it was backfilled, there could be some settling of the backfill.

On redirect examination, Mr. Bush agreed that he referred to it was a "hole" because Petitioner referred to it as a "hole." He further agreed that the depression depicted in the pictures was the same depression he saw on March 22nd.

The Application for Adjustment of Claim was entered into evidence at the time of arbitration as Arbitrator's Exhibit 2. The Application alleged a date of accident of March 21, 2011, that Petitioner stepped in a hole, and that he sustained injury to his right leg. (AX2).

The transcript of the deposition of Dr. George Paletta was entered into evidence at the time of arbitration as Petitioner's Exhibit 1. Dr. Paletta testified that he is an orthopedic surgeon whose practice is confined primarily to problems of the shoulder, elbow and knee. He testified that he is board-certified. (PX1).

Dr. Paletta testified that he first saw Petitioner on May 13, 2011 at the request of Dr. Keith Byler. He testified that Petitioner reported that about two months earlier he had injured his right knee, that he was a union electrician, that he was working on some gravel and that he stepped in a hole that resulted in a twisting injury to his right knee. He testified that Petitioner reported that he had undergone x-rays, that he was initially diagnosed with a knee strain and that he was treated with a knee sleeve or small brace, icing and anti-inflammatories. He testified that Petitioner reported that he continued to follow at Midwest

Occupational Medicine but was having continued complaints of pain, and that Dr. Byler recommended that he undergo an MRI. He testified that Petitioner reported that he followed up with Dr. Byler after the MRI scan and was told that he had a meniscus tear and that he needed an orthopedic evaluation. (PX1).

Dr. Paletta testified that when he first saw Petitioner, his chief complaint was mainly pain along the lateral joint line, but he complained that the whole knee felt somewhat abnormal for him. He testified that Petitioner reported that he was not having a lot of recurrent swelling and no mechanical symptoms, that he was having pain particularly with stairs, that he had been wearing the sleeve and that prior to this injury he had no history of right knee problems although he had a fracture of the left knee a number of years earlier. He testified that on examination, Petitioner had a "tiny bit" of swelling, that he had a normal examination of the kneecap of his patella and normal range of motion of the knee but had a lot of tenderness along the lateral joint line. He testified that the findings were suggestive of a tear of the lateral meniscus. (PX1).

Dr. Paletta testified that x-rays of the right knee showed that the right knee bony structure was normal and that there was no evidence of any fracture or other significant degenerative changes. He testified that he also reviewed the MRI of April 27, 2011, which demonstrated a tear of the lateral meniscus and some mild degenerative changes particularly of the patellofemoral joint as well as a mild effusion. He testified that his impression was that Petitioner had suffered a tear of the lateral meniscus and that he had some pre-existing degenerative changes of the patellofemoral joint, and that he recommended that he consider arthroscopy of the knee. He testified that the findings that pre-existed the work accident were the degenerative changes of the kneecap portion of the joint. He testified that he told Petitioner to try to minimize his squatting, kneeling and repetitive climbing activities, but that he could work as tolerated. He further testified that based on what Petitioner described to him, the mechanism of injury and his prior history, it was his opinion that the lateral meniscus tear was causally related to the work injury that Petitioner described. (PX1).

Dr. Paletta testified that he next saw Petitioner approximately eleven months later and that surgery was not done until April of 2012. He testified that based on his re-evaluation, they went ahead with the arthroscopic procedure. He testified that the post-operative diagnosis was that of a lateral meniscus tear of the right knee, patellofemoral chondromalacia and medial femoral condyle defect. He testified that he would have taken Petitioner off work post-operatively until he was seen for the initial post-operative visit on April 30, 2012, at which time Petitioner was doing quite well. He testified that Petitioner was complaining of a little bit of popping and grinding in the knee, but had noticed already improvement in his pain from his pre-operative status. He testified that on that date, he anticipated that Petitioner would be able to return to work as of May 14th. (PX1).

Dr. Paletta testified that Petitioner returned on June 18, 2012, at which time he was doing extremely well. He testified that Petitioner denied any pain or swelling, with the exception of some occasional discomfort with stairs or deep squatting/flexion of the knee. He testified that Petitioner had been returned to work but had not been called back because there was no work available. He testified that he recommended that Petitioner return to full activities, that he did not require additional treatment and that he was released from care at maximum medical improvement. He denied having seen Petitioner since June 18, 2012. (PX1).

Dr. Paletta testified that Petitioner's prognosis with regard to the meniscus tear long-term should be excellent, and that his opinion was that as of the last date he saw him, Petitioner should not require any additional care for the lateral meniscus tear. (PX1).

On cross examination, Dr. Paletta agreed that Petitioner was a "large man" and was 50 years of age at the last time that he saw him. He testified that the degenerative changes in the right knee were not uncommon. He agreed that arthritic changes were more common as we age, and there was certainly some

indication that obese individuals had an increased risk for degenerative joint disease. He testified that it was possible that meniscal tears could be related to degenerative conditions but in this case he did not believe that was the case given that Petitioner's degenerative changes did not involve the lateral component of the knee and the appearance of the meniscus tear, which had a parrot beak component which meant it was torn obliquely. (PX1).

On cross examination, Dr. Paletta agreed that Petitioner indicated that he stepped in a hole. He testified that what really mattered most to him was the load that was put on the knee when he stepped into whatever he stepped in. (PX1).

On redirect examination, Dr. Paletta agreed that Petitioner denied any prior history of right knee problems. (PX1).

The Medical Bills Exhibit was entered into evidence at the time of arbitration as Petitioner's Exhibit 2.

The medical records of Midwest Occupational Medicine were entered into evidence at the time of arbitration as Petitioner's Exhibit 3. Petitioner was seen on March 24, 2011, at which time it was noted that Petitioner stated that he stepped into a gravel hole and twisted the knee. It was noted that Petitioner reported that he felt a pop, but that he was not really sure if he torqued it or if he put it into varus or valgus stress. It was noted that it popped quite a bit but did not actually catch, lock or feel as though it was going to give out on him. It was noted that an x-ray was recommended, as well as Petitioner being put in a knee sleeve with a patella stabilizer and allowed to do activity as tolerated. (PX3).

The records of Midwest Occupational Medicine reflect that at the time of the April 8, 2011 visit, it was noted that Petitioner stated that overall he had seen a fair amount of improvement but that on that date his knee was much sorer than it had been the last few days. Petitioner denied any specific intervening event, although he did indicate that the day prior he was carrying some things that were fairly heavy and had to go up some stairs. It was noted that Dr. Byler recommended to continue watching it, and Petitioner was instructed to return in three weeks. At the time of the April 21, 2011 visit, Petitioner stated that it was not getting any better and was getting worse. It was noted that if Petitioner was up on the knee for much time, he had swelling and increased pain. It was recommended that Petitioner undergo an MRI. At the time of the April 29, 2011 visit, it was noted that the MRI showed a tear of the posterior horn of the lateral meniscus with a meniscal fragment displaced involving the body of the lateral meniscus and also a small to moderate joint effusion. It was noted that Petitioner needed a referral to an orthopedic surgeon. (PX3).

The medical records of Belleville Memorial Hospital were entered into evidence at the time of arbitration as Petitioner's Exhibit 4. Petitioner underwent x-rays of the right knee on March 24, 2011, which were interpreted as revealing no fracture, dislocation, unusual soft tissue calcification or other bony abnormality. (PX4).

The medical records of Imaging Center at Wolf Creek were entered into evidence at the time of arbitration as Petitioner's Exhibit 5. Petitioner underwent an MRI of the right knee on April 27, 2011, which was interpreted as revealing tears involving the posterior horn of the lateral meniscus in an oblique fashion with a horizontal tear with meniscal fragment displacement involving the body of the lateral meniscus, small-to-moderate joint effusion. (PX5).

The daily notes for John Bush were entered into evidence at the time of arbitration as Petitioner's Exhibit 6. The note dated March 21, 2011 noted that at the end of the shift on that date, Petitioner was escorted in by his foreman stating that Petitioner had twisted his knee. It was noted that Petitioner stated that he was working at a "fab" table outside by the east door between Units #1 and #2 when he stepped

into a hole and popped his knee. It was also noted that Petitioner indicated that the pain was on the outside of his right knee, and that he said he did not fall down but stepped back. (PX6).

The note dated March 22, 2011 noted that Petitioner's foreman indicated that Petitioner was experiencing some stiffness but was not hurting at that time. It was noted that he went to the overhead door and observed the depression that Petitioner said he stepped in, and that piping had been installed in the location and the backfill had settled some, leaving a depression of about three inches. It was noted that the laborers were asked to bring a shovel and fill the hole in, and that the foreman stated that there were areas all over the jobsite that were similar to this area and that you could not make it perfect for everyone. (PX6).

The note dated March 23, 2011 noted that Petitioner and his foreman were discussing knee injuries and associated issues. Petitioner stated that his knee became swollen after walking into the trailer from the contractor parking lot, and that when elevated, it would go back down. It was noted that Petitioner stated his knee did not hurt much but was uncomfortable, and that he stated he could do his job duties on that date. It was noted that Petitioner requested to see a physician, and that Petitioner continued to point to the outside of his right knee as the point of tenderness. It was also noted that Petitioner stated that he had experienced some similar symptoms with his left knee after he damaged it when he fell off a concrete ledge while wearing steel-spike golf shoes. (PX6).

Various photographs of the incident site were entered into evidence at the time of arbitration as Respondent's Exhibit 1.

The *curriculum vitae* of Kevin Vidal was entered into evidence at the time of arbitration as Respondent's Exhibit 2.

The transcript of the deposition of Dr. Joseph Williams was entered into evidence at the time of arbitration as Respondent's Exhibit 3. Dr. Williams testified that he is board-certified in orthopedic surgery. He testified that he authored a report dated September 20, 2011 pertaining to his examination of Petitioner. (RX3).

Dr. Williams testified that Petitioner gave a history of stepping into a hole and twisting his right knee. He testified that he reviewed the photographs that were provided which purported to be the area that he stepped in, and that Petitioner stated that he thought it was not the appropriate area and that the area that he stepped in was rock. He testified that Petitioner stated that he did not fall down, but stepped back. (RX3).

Dr. Williams testified that he reviewed various medical records and documentation, and that he also had opportunity to review the MRI films and report from April 27, 2011. He testified that Petitioner had significant degenerative changes throughout the entire knee, that his knee had wear and tear changes, that Petitioner was morbidly obese and that he had degenerative changes consistent with morbid obesity. He testified that the MRI also showed there was a tear involving the posterior horn of the lateral meniscus, and grade 2 to 3 chondromalacia changes. He testified that the most significant thing from Petitioner's past medical history was that he had a fracture to his left knee for which he had to have open reduction and internal fixation. (RX3).

Dr. Williams testified that the diagnosis that he rendered including severe degenerative changes in the chondromalacia in several different areas of Petitioner's knee and a degenerative tear of the lateral meniscus, as well as osteoarthritis of the patellar femoral joint of his right knee. He further indicated that Petitioner had chronic and long-standing arthritis and degenerative changes of the lateral meniscus as well. He testified that he based his opinion on primarily the MRI and his examination. (RX3).

Dr. Williams testified that he did not believe that Petitioner needed any additional medical treatment relative to the alleged injury of March 21, 2011, but that he required additional treatment related to his osteoarthritis such as medications, cortisone injections and physical therapy. He testified that he did not believe that Petitioner was a surgical candidate given that he had not been treated conservatively. He further testified that he did not believe that Petitioner's right knee condition was related to the March 21, 2011 accident but rather that his condition was related to his being morbidly obese. (RX3).

Dr. Williams testified that he disagreed with Dr. Paletta's opinion that Petitioner sustained an acute tear as a result of the injury because there was not degeneration in the area of the tear to have caused the tear, and indicated that the MRI, per his review, showed that it was a degenerative change on the lateral meniscus. He testified that he believed the degeneration was throughout the entire knee. He testified that it did not appear to him that Petitioner suffered a parrot beak tear, and that he did not believe the tear was related to the March 21, 2011 alleged accident. (RX3).

Dr. Williams testified that he believed that Petitioner's medical findings were inconsistent with the mechanism of injury he described, and that he saw the pictures which showed a depression in the rocks less than two inches deep. He testified that Petitioner stepped on gravel that was slightly uneven. He testified that the description that Petitioner's knee bent inward and twisted was inconsistent with the description provided to him, and that Petitioner stated to him that he was not sure what happened to his knee. (RX3).

Dr. Williams testified that at the time of the September 20, 2011 examination, he opined that Petitioner could go back to work and noted that Petitioner had been working on a daily basis until he was laid off in June and further noted that the injury occurred in March. He testified that the classic activity that would cause a lateral meniscus tear acutely in the knee would be a running injury when you stopped suddenly and changed directions quickly with your foot planted on the ground. (RX3).

On cross examination, Dr. Williams agreed that he saw Petitioner on one occasion, that he had not seen him since September 20, 2011 and that he did not know how Petitioner was doing. He agreed that he was not supplied with the operative report at the time the examination was performed and that he did not prepare a supplemental report concerning the findings in the operative report. He agreed that there was a discrepancy in how Petitioner explained the accident occurred and what was provided to him in the photographs by his employer. He agreed that he was not aware that after the accident, the laborers put rock in the hole. (RX3).

On cross examination, Dr. Williams agreed that Petitioner denied having any prior problems with his right leg or knee. He agreed that Petitioner filled out a patient questionnaire where he told him that prior to the accident, he had no symptoms whatsoever in the right knee. He agreed that in all of the medical records he reviewed prior to March 21, 2011, there was no symptomatology referable to the right knee. He testified that Petitioner stated that he popped his knee, but did not say that he had a twisting injury. He did, however, agree that the medical records indicated that during the injury, he sustained a twist to the knee. (RX3).

On cross examination, Dr. Williams agreed that twisting injuries or torqueing of the knee can cause a lateral meniscus tear if there was a sufficient force placed upon the lateral part of the knee. He agreed that his opinion that there was no causal connection was based on the assumption that the photographs correctly and accurately detail the scene of the area where Petitioner said he had his accident. He agreed that if there was a hole at the time and that Petitioner stepped into a hole causing a twisting of his right knee, it was possible that the lateral meniscus tear could have occurred at that time. (RX3).

On cross examination, Dr. Williams agreed that Dr. Mattingly, the radiologist who reviewed the MRI, stated that there was only a grade 2 chondromalacia approaching grade 3 chondromalacia to the medial

patella area. He agreed that Dr. Mattingly did not mention that there were degenerative changes in the lateral compartment. He agreed that the lateral compartment was free of any degenerative changes. (RX3).

On cross examination, Dr. Williams agreed that he indicated that Petitioner was not a candidate for surgery because no conservative treatment had been tried yet. He agreed that assuming conservative measures were attempted and failed, it would be proper protocol to do a diagnostic arthroscopic surgery. He testified that it would surprise him that Petitioner had surgery and had an excellent result, was able to return to work and was asymptomatic. He testified that a parrot beak tear was usually a wear and tear type of injury, but agreed that it could be caused traumatically. (RX3).

On cross examination, Dr. Williams testified that it was his belief that Petitioner was magnifying his symptoms given his suntanned legs and ability to work from March 21st until June when he was laid off. He agreed, however, that he did not know how many days he was working or what type of work he was doing. He further agreed that he did not know if he was a working or non-working foreman. (RX3).

On redirect examination, Dr. Williams testified that his opinion that the meniscus tear was related to a degenerative process was based on primarily the MRI and his interpretation of the MRI. He testified that removing all descriptions of the accident, his opinion was that he did not believe Petitioner had sustained an acute injury. He testified that the MRI revealed that it was not a sharp tear and was dull, like it had been there for quite a long time. (RX3).

A photograph containing the signature of Travis Webb was entered into evidence at the time of arbitration as Respondent's Exhibit 4.

The transcript of the deposition of Travis Webb was entered into evidence at the time of arbitration as Respondent's Exhibit 5. Mr. Webb testified that at one time he worked with Petitioner for Respondent, and that he worked for Respondent in March of 2011 as the foreman over a crew. He testified that Petitioner was a member of his electrical crew and was a journeyman wireman running conduit, pulling wire and terminating. (RX5).

Mr. Webb testified that on or about March 21, 2011, Petitioner came to him and told him that he had stepped into a depression or hole and claimed that he injured himself, and that he took that information to the safety crew which included John Bush. He testified that there was a point in time where Petitioner showed him the place where he walked, and that Respondent's Exhibit 4 was a picture of the spot where Petitioner had fallen into the hole and that it was the place that Petitioner pointed out to him. (RX5).

Mr. Webb testified that it was within a short time after Petitioner reported the accident to him that he went out and had Petitioner show him where it was. He testified that he placed the level on the depression. He testified that there was no indication that anything had happened to the area to change its appearance, and that he did not recall Petitioner stating that the area was different than it was previously. (RX5).

On cross examination, Mr. Webb denied recalling seeing any holes that were 6-8 inches deep and 3.5-4 feet in diameter. When asked if he knew what Petitioner was doing at the time he stepped into the hole, Mr. Webb responded that to the best of his memory Petitioner was coming in to work. He did not recall if Petitioner was carrying items back and forth several times across the walkway between unit one and unit two, but did not think so. He testified that that this would have been the day shift. (RX5).

On cross examination when asked if he remembered what time it was that he would have seen Petitioner to talk to him about the accident where he stepped in the hole, Mr. Webb responded that to the best of his memory Petitioner was coming in to work and their arrival time was 7:00 a.m. (RX5).

On cross examination, Mr. Webb agreed that the superintendent was John Bush. He testified that he did not know anything about prior to the accident there having been a pipe that was installed or repaired and that there was some settling that occurred. When asked if the area looked like it had had backfill put in, he responded that they were always adding rock here and there but that when the picture was taken there had been no rock spread that day in that area. He agreed that in looking at the group photos, it looked like some rocks were new as compared to some that were darker in appearance. He testified that there was an old railroad bed in the background where the truck was parked alongside of it and that the stacks were right above that so there were always black coal particles lying around there at all times. (RX5).

On cross examination, Mr. Webb denied recalling a conversation that he had with Mr. Bush where Mr. Bush asked that the laborers be summoned in order to put gravel into the holes. He testified that he did, however, remember that they got filled. He agreed that they were filled after Petitioner's incident, but could not recall when. (RX5).

On redirect examination, Mr. Webb testified that when he stated they were filled, he was talking about depressions just in the area pictured and that there was more than just the one low spot. He testified that the ground was mostly rock and that they had lifts turning tires that were leaving depressions, and that everything in that area got cleaned up but he could not say the whole job site did. When asked if it was possible that this happened in the afternoon, Mr. Webb responded that it could have and that he really did not recall. He agreed that the key was the location identified by Petitioner. (RX5).

On redirect examination, Mr. Webb testified that he would have gone out to look within the hour after Petitioner's incident. He testified that Petitioner did not actually go with him, but that he put him in the area as he went by because Petitioner could not walk. He testified that he could not remember how he got to that spot exactly, but that Petitioner had been to that area and pointed out the spot to him. He testified that Petitioner personally pointed out the spot to him. (RX5).

On further cross examination when asked if there were any depressions that were deeper than the one shown, Mr. Webb responded that he could not answer that as this was the only spot he was taken to. He testified that he did not remember one way or the other whether there could have been another spot. (RX5).

On further redirect examination, Mr. Webb testified that to the best of his recollection this was the spot that Petitioner pointed out to him. (RX5).

CONCLUSIONS OF LAW

With respect to disputed issue (C) pertaining to accident, the Arbitrator finds that Petitioner has met his burden of proving that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on March 21, 2011.

To obtain compensation under the Illinois Workers' Compensation Act, a claimant must show by a preponderance of the evidence that he has suffered a disabling injury arising out of and in the course of his employment. 820 ILCS 305/2; *Metropolitan Water Reclamation District of Greater Chicago v. Illinois Workers' Compensation Comm'n*, 407 Ill. App. 3d 1010, 1013 (2011); *Caterpillar Tractor Co. v. Indust. Comm'n*, 129 Ill. 2d 52, 57 (1989). However, the fact that an injury arose "in the course of" the employment is not sufficient to impose liability, for to be compensable, the injury must also "arise out of" the employment. *Id.* at 58.

The "arising out of" component refers to an origin or cause of the injury that must be in some risk connected with or incident to the employment, so as to create a causal connection between the employment and the accidental injury. *Id.* There are three categories of risk to which an employee may be exposed: (1) risks distinctly associated with the employment; (2) risks personal to the employee; and (3) neutral risks, which have no particular employment or personal characteristics. *Springfield Urban League v. Illinois Workers' Compensation Comm'n*, 2103 IL App (4th) 120219WC, ¶ 27; *Young v. Illinois Workers' Compensation Comm'n*, 2014 IL App (4th) 130392WC. Injuries resulting from a neutral risk are not generally compensable and do not arise out of the employment unless the employee was exposed to the risk to a greater degree than the general public. *Id.*

The "in the course of" component refers to the time, place and circumstances under which the accident occurred. *Illinois Bell Telephone Co. v. Indust. Comm'n*, 131 Ill. 2d 478, 483 (1989). If an injury occurs within the time period of employment, at a place where the employee can reasonably be expected to be in the performance of her duties, and while she is performing those duties or doing something incidental thereto, the injuries are deemed to have been received in the course of the employment. *Caterpillar Tractor Co.*, 129 Ill. 2d at 58. "Injuries 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, or within a reasonable time before and after work, are generally deemed to have been received in the course of the employment." *Johnson v. Illinois Workers' Compensation Comm'n*, 2011 IL App (2d) 100418WC, ¶ 21.

In the case at hand, the Arbitrator notes that Respondent has argued that Petitioner has not shown any defect and has not shown any increased risk. The Arbitrator finds, however, that Petitioner, by virtue of his employment, was exposed to that hazard to a greater degree than the general public, particularly in light of the fact that Petitioner was carrying 60-75 pounds at the time of the accident, that he had made several such trips carrying the items and that he walked around a co-worker so as to avoid hitting him while carrying the heavy materials. The Arbitrator finds that the frequency with which Petitioner traversed the area in which he fell, when considered with his testimony that the condition of the area as depicted in the photographs upon which Respondent's expert witnesses relied was not the same as that at the time of the incident at issue, are cumulatively supportive facts for the Arbitrator to conclude that Petitioner's accident arose out of and in the course of his employment.

As a result thereof, the Arbitrator finds that Petitioner met his burden of proof in establishing that he sustained accidental injuries that arose out of and in the course of his employment with Respondent on March 21, 2011.

With respect to disputed issue (F) pertaining to causation, the Arbitrator finds that Petitioner's current condition of ill-being is causally related to the accident of March 21, 2011.

The Arbitrator finds that the medical evidence in this case suggests that Petitioner had pre-existing issues in the right knee, but Petitioner's testimony reflects that prior to March 21, 2011, he did not have any issues with regard to his right leg or knee and that he also denied ever having seen any doctors before March 21, 2011 for any right leg or knee issues or symptomatology. The Arbitrator notes that there were no medical records entered into evidence at the time of arbitration demonstrating that Petitioner underwent any treatment for his right knee prior to the accident at issue so as to rebut Petitioner's testimony on this issue.

Placing greater weight upon the opinions of Dr. Paletta who testified that based on what Petitioner described to him, the mechanism of injury and his prior history, it was his opinion that the lateral meniscus tear was causally related to the work injury that Petitioner described, the Arbitrator finds that

Petitioner has met his burden of proving that his current condition of ill-being is causally connected to the accident of March 21, 2011.

With respect to disputed issue (J) pertaining to necessary medical services, in light of the Arbitrator's aforementioned conclusions, the Arbitrator finds that Petitioner's care and treatment was reasonable, necessary, and causally related to his work accident of March 21, 2011. As a result thereof, Respondent shall pay all reasonable and necessary medical services as contained in Petitioner's Exhibit 2, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit for all medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

With respect to disputed issue (K) pertaining to temporary total disability benefits, the Arbitrator notes that Petitioner seeks temporary total disability benefits from April 16, 2012 through May 14, 2012. (AX1).

The Arbitrator notes that Petitioner underwent surgery on April 19, 2012. Furthermore, Dr. Paletta testified that he would have taken Petitioner off work post-operatively until he was seen for the initial post-operative visit on April 30, 2012, at which time Petitioner was doing quite well. Dr. Paletta testified that on that date, he anticipated that Petitioner would be able to return to work as of May 14th. (PX1). The Arbitrator further notes that a work restriction slip was attached to the deposition transcript as Petitioner's Exhibit 2 and reflected that Petitioner was allowed to return to work full duty and was dated May 13, 2011 [*sic*]. (PX1). As a result thereof, the Arbitrator finds that Respondent shall pay temporary total disability benefits for a period of 3 4/7 weeks, commencing April 19, 2012 through May 13, 2012, given the Arbitrator's findings with respect to disputed issues (C) and (F).

With respect to disputed issue (L) pertaining to the nature and extent of Petitioner's injuries, the Arbitrator notes that Petitioner's injuries occurred on March 21, 2011 and, as such, the Arbitrator will not specifically be addressing the five factors under Section 8.1b of the Act in the determination of permanent partial disability.

The Arbitrator finds that the medical records in this case demonstrate that Petitioner sustained a lateral meniscus tear for which he underwent surgery on April 19, 2012 which included (1) right knee exam under anesthesia; (2) right knee diagnostic arthroscopy; (3) right knee arthroscopy with subtotal lateral meniscectomy; (4) right knee arthroscopy with debridement and chondroplasty, patellofemoral articulation; (5) right knee arthroscopy with debridement and chondroplasty of medial femoral condyle, medial tibiofemoral compartment. (PX1). While Petitioner testified as to various ongoing issues involving the right knee, the Arbitrator notes that Dr. Paletta testified that Petitioner's prognosis with regard to the meniscus tear long-term should be excellent, and that his opinion was that as of the last date he saw him, Petitioner should not require any additional care for the lateral meniscus tear. (PX1). Having reviewed the record in its entirety, the Arbitrator concludes that Petitioner sustained permanent partial disability to the extent of 15% loss of use of the right leg under Section (e) of the Act.

With respect to disputed issue (O) pertaining to mileage, the Arbitrator denies Petitioner's request for mileage reimbursement for travel to and from his medical appointments.

The Arbitrator notes that Petitioner admitted that there were two hospital facilities where he lived at the time he underwent treatment, and that he did not even check with either facility as to whether they had MRI imaging capabilities. The Arbitrator notes that Petitioner admitted that there were orthopedic surgeons that practiced in his area, and that he underwent physical therapy locally as well. The Arbitrator also notes that Petitioner admitted that he specifically elected to seek treatment with Dr. Paletta due to his reputation.

As a result of the foregoing, the Arbitrator denies Petitioner's request for mileage reimbursement for travel to and from his medical appointments given his failure to demonstrate the unavailability of such medical treatment closer to home.

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Billy Callaway,

Petitioner,

vs. NO: 10 WC 49695

17IWCC0525

Sears,

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 accident, medical expenses, 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 December 22, 2015, is hereby affirmed and adopted.

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

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

17IWCC0525

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 22 2017
TJT:yl
o 7/25/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

CALLAWAY, BILLY
Employee/Petitioner

Case# **10WC049695**

SEARS
Employer/Respondent

17IWCC0525

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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

1824 STRONG LAW OFFICES
MICHAL BRANDOW
3100 N KNOXVILLE AVE
PEORIA, IL 61603

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

17IWCC0525

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Billy Callaway
Employee/Petitioner

Case # **10** WC **49695**

v.

Sears
Employer/Respondent

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Anthony C. Erbacci**, Arbitrator of the Commission, in the city of **Peoria**, on **November 12, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **November 26, 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 $**8,024.64**; the average weekly wage was $**154.32**.

On the date of accident, Petitioner was **30** years of age, ***single*** with **2** dependent children.

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

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

Respondent shall be given a credit of $**2,777.76** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**2,777.76**.

ORDER

Respondent shall pay Petitioner temporary total disability benefits of $**154.32**/week for **20 4/7** weeks, commencing **November 27, 2010** through **April 19,2011**, as provided in Section 8(b) of the Act.

Respondent shall be given a credit of $**2,777.76** for temporary total disability benefits that have been paid.

Respondent shall pay reasonable and necessary medical services of $**65,818.60**, as provided in Sections 8(a) and 8.2 of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $**154.32**/week for **87.5** weeks, because the injuries sustained caused the **17.5%** loss of the person as a whole, as provided in Section 8(d)2 of the Act.

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

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

Arbitrator Anthony C. Erbacci

December 17, 2015
Date

DEC 22 2015

FACTS:

The Petitioner testified that on November 26 2010, he was working for the Respondent in the merchandise pickup area. The Petitioner testified that it was "Black Friday", the day after Thanksgiving, and it was an extremely busy day with a larger than normal number of customers picking up a larger than normal number of items. The Petitioner testified that his job that day required him to assist customers with loading of their purchases into their vehicles and that he had to lift appliances without help on several occasions. The Petitioner testified that as he was working, he began to notice pain in his low back. He testified that about five hours into his shift, he reported his back pain to his supervisor, Jesse Lockman, and requested a back support belt. The Petitioner testified that his request was refused and he was told to continue to work. The Petitioner testified that he continued to work for the rest of his shift and that he again told Jesse Lockman of his back pain. The Petitioner testified that Mr. Lockman never asked him to complete any paperwork. The Petitioner testified that when he attempted to get out of bed the next day, his legs kept giving out on him and he then sought treatment at OSF Prompt Care.

The records of OSF Prompt Care demonstrate that the Petitioner was seen there on November 28, 2010 with complaints of low back pain. Those records indicate that the Petitioner reported that he blacked out two weeks ago, that he was seen in the emergency room and that since that time he had been having back pain on and off with weakness. It was also noted that the Petitioner worked at Sears at customer pick up, but no specific history of any injury at work is noted. Those records also demonstrate that prior to November 26, 2010, the Petitioner went to Prompt Care on October 28, 2010 to be checked out for dizziness. No mention of any back injury or complaints was noted at that time.

On December 1, 2010, the Petitioner saw his primary care doctor, Dr. Multani. The records that were admitted into evidence indicate that the Petitioner had been a patient of Dr. Multani since August 9, 2010. None of Dr. Multani's records prior to November 26, 2010 contain any indication that the Petitioner complained of or received treatment for low back pain or problems. When the Petitioner saw Dr. Multani on December 1, 2010, he was noted to complain of "new worsening back pain" and to have reported that "he lifted something heavy last week while at work." An MRI was ordered.

The Petitioner underwent an MRI of the lumbar spine on December 3, 2010 at OSF Healthcare. The radiologist's impression was a rightward L5-S1 disc protrusion causing lateral recess encroachment and minimal right L5-S1 foraminal encroachment. A relatively shallow L4-5 disc protrusion was also noted, but did not appear to result in significant mechanical neural impingement. The Petitioner followed up with Dr. Multani on December 10, 2010 with continued complaints of low back pain. The Petitioner was noted to have reported that he tried to go back to work the day prior but his back pain became worse. Dr. Multani referred the Petitioner for physical therapy and a neurosurgical consultation.

On December 21, 2010, the Petitioner saw Dr. Kube. The Petitioner's complaints on this date were noted to be back pain and right thigh pain that had been present for six weeks and it was also noted that he related working a significant amount of time on black Friday experiencing increasing low back pain and right-sided leg pain. Dr. Kube's assessment was that the Petitioner likely suffered a ruptured disc at L5-S1 on the right side over the course of some heavy lifting. Dr. Kube recommended physical therapy and a lumbar epidural steroid injection at the L5–S1 level. The Petitioner began a course of physical therapy at Champion Fitness on December 27, 2010. On December 29, 2010, he

underwent the lumbar epidural steroid injection at L5-S1. When the Petitioner followed-up with Dr. Kube, the doctor noted a lack of response to the injection and he recommended an additional week of physical therapy. At the follow-up visit on January 20, 2011, Dr. Kube recommended surgery as the Petitioner's symptoms had not resolved.

On February 9, 2011, the Petitioner underwent a right sided hemilaminotomy with microdiscectomy at the L5–S1 right side. The pre and postoperative diagnoses were herniated nucleus pulposus at the right-side L5–S1 with radiculopathy. The Petitioner resumed therapy at Champion Fitness and continued doing so through April 13, 2011. When Dr. Kube saw the Petitioner on March 24, 2011 it was noted that he was doing exceptionally with no pain on examination and he was essentially back to normal. The Petitioner was released to return to work at the medium activity level with no lifting greater than 50 pounds and it was noted that it would take up to twelve weeks to get the full healing of the disc. The Petitioner was unable to return to work due to those restrictions. The petitioner followed up with Dr. Kube on April 19, 2011 and was noted to be doing great with no pain and great motion and strength. At that time, Dr. Kube released the Petitioner to return to work without restrictions and he discharged the Petitioner from his care.

The Petitioner testified that he was unable to return to work at the Respondent as it had closed down while he was off work. The Petitioner testified that between the date of accident of November 26, 2010 and April 19, 2011, he did not work, but that during that time period he was paid $2,777.76 in temporary total disability benefits. The Respondent did not dispute the time period that the Petitioner was off, only its liability for payment of benefits. The Petitioner testified that he eventually found employment as a welder but he testified that there was no heavy lifting required at that job.

The Petitioner testified that after his discharge from care by Dr. Kube, he continued to experience back pain which required him to take additional medications and to follow up with Dr. Multani. The Petitioner testified that he continued to take medication following his surgery up until the end of 2012.

Dr. Multani's records demonstrate that the Petitioner continued to seek treatment between late April of 2011 through March 21, 2012, but primarily for unrelated medical conditions. The records of these visits document complaints of low back and neck pain rated at 4/10, though these complaints did not appear to be the focus of many of these visits. The records also demonstrate that the Petitioner was prescribed various medications, including Mobic which prescriptions were issued on August 2, 2011, October 10, 2011, and March 5, 2012.

At the request of the Respondent, the Petitioner was examined by Dr. Jay Levin on March 1, 2012. Dr. Levin's report of that date was admitted into the record as Respondent's Exhibit 1. Dr. Levin also prepared an addendum report dated April 24, 2012, which was admitted into the record as Respondent's Exhibit 2. In his two reports, Dr. Levin noted the Petitioner's history was that he was performing approximately two hundred lifts on black Friday when he experienced back pain. The history of the Petitioner's medical treatment is also documented in Dr. Levin's reports. Dr. Levin noted the November 28, 2010 office visit with Dr. Gorman in which the Petitioner had a history of blacking out two weeks prior and experiencing back pain since that time. Based upon the medical records, Dr. Levin opined that the Petitioner's condition of ill-being was not causally related to the work accident of November 26, 2010, insofar as the Petitioner's complaints of back pain and leg pain predated the alleged date of accident.

The Petitioner returned to Dr. Kube on January 31, 2013 with complaints of back pain. The notes indicate that the Petitioner had an injury at work over one year prior and his back pain was slightly increased over time. It was noted that the Petitioner had a prior surgery on February 9, 2011 that provided him relief, and that this was a new issue that had arisen. The Petitioner was noted to have complaints of back pain with occasional left leg pain, and the assessment was degenerative disc disease, spinal stenosis, sprain/strain, disc displacement in the cervical intervertebral disc, thoracic or lumbosacral neuritis, radiculitis, displacement of the lumbar and vertebral disc and lumbago. The Petitioner was prescribed a trigger point injection, a repeat MRI, and physical therapy.

On February 6, 2013, the Petitioner underwent a physical therapy initial evaluation with Champion Physical Fitness. The note of that initial valuation indicates that six months prior the Petitioner started to have low back stiffness and pain when he would wake up in the morning and he had been experiencing a gradual increase in pain since that time.

After undergoing physical therapy and a trigger point injection, the Petitioner underwent an MRI of the lumbar spine on March 4, 2013. The radiologist's impression was postoperative changes at L5-S1 on the right with an asymmetric disc/osteophyte complex. There was a nerve root/sheath complex that was displaced posteriorly to the level of the disc. Also noted was an additional far right lateral disc protrusion encroaching upon the posterior/inferior aspect of the L5 foramen. The previously imaged small disc herniation at the L4-5 level was also noted.

The Petitioner followed up with Dr. Kube on March 19, 2013. Dr. Kube noted that the MRI revealed a "very large blowout" of the L5-S1 disc on the right side, which appeared to be a degenerative progression. It was noted that the Petitioner had stenosis at the L5-S1 level on the right side, and the Petitioner was continued with conservative treatment measures.

On April 26, 2013 the Petitioner presented to Dr. Charles Carlin with Primary Care Chiropractic on referral from Champion Physical Therapy. At this visit the Petitioner reported that he was undergoing physical therapy for an original work injury that occurred in 2010, and that his symptoms were still present after back surgery. Dr. Carlin performed chiropractic sessions on the Petitioner until August 14, 2013 at which time the Petitioner was deemed to have reached maximum medical improvement.

At the request of the Respondent, the Petitioner was again examined by Dr. Jay Levin on March 24, 2014. Dr. Levin's report of that date was admitted into the record as Respondent's Exhibit 3. Dr. Levin also prepared an addendum report dated April 28, 2014, which was admitted into the record as Respondent's Exhibit 4. In his reports, Dr. Levin noted that the Petitioner related that he was taking anti-inflammatory medications and Mobic through December of 2012 but had to stop. The Petitioner denied a new injury but noticed on December 31, 2012 that he was getting low back pain and problems again. Dr. Levin reiterated his opinions that the Petitioner's prior course of medical treatment, while reasonable, was unrelated to any kind of work accident.

On April 28, 2014, the Petitioner sought a second opinion with Dr. Mulconray with Midwest Orthopedic Center. Dr. Mulconray's assessment was status post lumbar decompression, degenerative disc disease, and lumbar-based pain. Dr. Mulconray recommended the Petitioner continue staying active and continue working out at the gym. At a follow up visit with Dr. Mulconray on October 29, 2014 the Petitioner reported that he continued to experience lumbar based pain and right lower extremity pain. Dr. Mulconray again prescribed a home exercise program and

medications, and he indicated that the Petitioner could expect to have ongoing symptoms intermittently. The Petitioner was instructed to follow up on an as needed basis.

The Petitioner testified that he currently experiences stiffness in his back after sitting in car for prolonged periods as well as occasional muscle spasms. He testified that he currently takes over the counter pain medications, up to two to three times per week and that he does not feel he is able to lift any more than one hundred pounds.

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 to an onset of back pain while he was lifting heavy objects in the performance of his regular job duties on November 26, 2010. The Petitioner sought medical treatment for his complaints two days later at OSF Promptcare. While no specific history of a work accident or lifting incident is mentioned in the record of that visit, there is a notation that the Petitioner worked at Sears at customer pick up. When the Petitioner saw his regular physician, Dr. Multani, on December 1, 2010, the Petitioner was noted to complain of back pain after "he lifted something heavy last week while at work." The Petitioner then underwent an MRI which was reported to demonstrate a herniated disc at L5-S1. The medical records relating to the Petitioner's treatment immediately prior to November 26, 2010 do not reflect that the Petitioner had any complaints of back pain or problems.

The Arbitrator notes that the Petitioner's testimony as to an injury while lifting heavy objects at work on November 26, 2010, while not particularly specific, was plausible, credible and uncontradicted. The Petitioner's testimony is also supported by the history noted in Dr. Multani's record of December 1, 2010.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that an accident that arose out of and in the course of the Petitioner's employment with the Respondent did occur on November 26, 2010.

In Support of the Arbitrator's Decision relating to (E.), Was timely notice of the accident given to Respondent, the Arbitrator finds and concludes as follows:

The Petitioner testified that he gave notice of his injury to his supervisor Jesse Lockman on the day the accident occurred. The Respondent presented no evidence or testimony which contradicted or rebutted the Petitioner's testimony or demonstrated that it was in any way prejudiced by any alleged failure to provide timely or adequate notice.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that timely notice of the accident was provided to the Respondent.

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

Following his injury on November 26, 2010, the Petitioner sought medical treatment with Dr. Multani who ordered physical therapy and an MRI, and referred the Petitioner to Dr. Kube. An MRI of the lumbar spine was performed on the Petitioner on December 3, 2010 and was reported to demonstrate an L5-S1 disc protrusion causing lateral recess encroachment and minimal right L5-S1 foraminal encroachment. Dr. Kube's assessment was that the Petitioner likely suffered a ruptured disc at L5-S1 on the right side over the course of some heavy lifting. Dr. Kube prescribed physical therapy and a lumbar epidural steroid injection at the L5–S1 level. The physical therapy and the injection failed to provide the Petitioner with any significant relief and Dr. Kube recommended surgery.

On February 9, 2011, the Petitioner underwent a right sided hemilaminotomy with microdiscectomy at the L5–S1 right side. The Petitioner underwent a course of post-surgical physical therapy through April 13, 2011. Dr. Kube noted that he was doing exceptionally after the surgery with no pain on examination. On April 19, 2011 Dr. Kube noted that the Petitioner was doing great with no pain and great motion and strength, and he released the Petitioner to return to work without restrictions. Dr. Kube also released the Petitioner from his care at that time.

The Petitioner testified that after his discharge from care by Dr. Kube, he continued to experience back pain which required him to take additional medications and to follow up with Dr. Multani. The Petitioner testified that he continued to take medication following his surgery up until the end of 2012.

The Petitioner returned to Dr. Kube on January 31, 2013 with complaints of back pain. The notes indicate that the Petitioner had an injury at work over one year prior and his back pain was slightly increased over time. It was noted that the Petitioner had a prior surgery on February 9, 2011 that provided him relief, and that this was a new issue that had arisen. The Petitioner was noted to have complaints of back pain with occasional left leg pain, and the assessment was degenerative disc disease, spinal stenosis, sprain/strain, disc displacement in the cervical intervertebral disc, thoracic or lumbosacral neuritis, radiculitis, displacement of the lumbar and vertebral disc and lumbago. The Petitioner was prescribed a trigger point injection, a repeat MRI, and physical therapy.

After undergoing physical therapy and a trigger point injection, the Petitioner underwent an MRI of the lumbar spine on March 4, 2013. The radiologist's impression was postoperative changes at L5-S1 on the right with an asymmetric disc/osteophyte complex. There was a nerve root/sheath complex that was displaced posteriorly to the level of the disc. Also noted was an additional far right lateral disc protrusion encroaching upon the posterior/inferior aspect of the L5 foramen.

On April 28, 2014, the Petitioner sought a second opinion with Dr. Mulconray. Dr. Mulconray's assessment was status post lumbar decompression, degenerative disc disease, and lumbar-based pain. Dr. Mulconray recommended the Petitioner continue staying active and continue working out at the gym. At a follow up visit with Dr. Mulconrey on October 29, 2014 the Petitioner reported that he continued to experience lumbar based pain and right lower extremity pain. Dr. Mulconray again prescribed a home exercise program and medications, and he indicated that the Petitioner could

expect to have ongoing symptoms intermittently. The Petitioner was instructed to follow up on an as needed basis.

The Petitioner testified that he currently experiences stiffness in his back after sitting in car for prolonged periods as well as occasional muscle spasms. He testified that he currently takes over the counter pain medications, up to two to three times per week and that he does not feel he is able to lift any more than one hundred pounds.

While the Arbitrator notes the opinions of Dr. Jay Levin, the Arbitrator finds those opinions to be unpersuasive in the instant matter. Dr. Levin's opinions are based upon a strained interpretation of the Petitioner's medical records and are not really supported by the credible evidence in the record. The Petitioner testified that he did not have prior back problems and no evidence was introduced which clearly indicated that he had a prior problem with his low back. There is, similarly, no evidence that the Petitioner had any difficulty performing his job prior to November 26, 2010.

The Arbitrator notes that the Petitioner sought medical treatment for his back complaints almost immediately after the incident and an MRI conducted on December 3, 2010, less than a week after the incident, showed a right L5 S1 disc protrusion. The Petitioner underwent surgery for a herniated L5 S1 disc on February 9, 2011 and, following the surgery, his complaints resolved. The Petitioner then underwent physical therapy through April 13, 2011 and was eventually released by Dr. Kube at maximum medical improvement without restrictions on April 19, 2011.

The Petitioner testified that he continued to have back pain subsequent to his surgery, although Dr. Kube's records demonstrate that the Petitioner did well after the surgery and Dr. Kube discharged the Petitioner from his care at maximum medical improvement without restrictions on April 19, 2011. While the Petitioner continued to seek medical treatment with Dr. Multani from April of 2011 through March of 2012, that treatment was primarily for unrelated medical conditions and obtaining prescriptions for medication. The Petitioner sought no further medical care for his back complaints until he saw Dr. Kube again on January 31, 2013, almost two years after his discharge at maximum medical improvement. Additionally, the Petitioner was employed for a time as a welder during that period.

The Petitioner then underwent additional physical therapy at Champion Fitness from February 6, 2013 through May 22, 2013, and he was also referred to Primary Chiropractic for additional chiropractic treatment, and he continued physical therapy there until August 14, 2013. The Petitioner then sought another opinion with Dr. Mulconray at Midwest Orthopedic Center. Dr. Mulconray saw the Petitioner on April 28, 2014 and noted that the Petitioner had been dealing with pain since the surgery. He was still active and discussed treatment options. At a follow-up visit on October 29, 2014, Dr. Mulconray recommended a home exercise program and released the Petitioner from his care.

The Arbitrator finds that, as a result of the work accident of November 26, 2010, the Petitioner sustained a herniated disc at L5-S1, for which he underwent surgery and post-surgical physical therapy. 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 in his low back is causally related to the work injury of November 26, 2010.

In Support of the Arbitrator's Decision relating 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 and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

Based upon the Arbitrator's findings and conclusions relating to the issues of accident and causation, the Arbitrator finds that the medical services provided to the Petitioner through April 19, 2011 were reasonable, necessary, and causally related to the November 26, 2010 work injury. The Arbitrator finds that the Petitioner failed to prove that any medical treatment the Petitioner received after April 19, 2011was causally related to the November 26, 2010 work injury.

In Support of the Arbitrator's Decision relating to (K.), What temporary benefits are due, the Arbitrator finds and concludes as follows:

The Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

The Petitioner claimed to be entitled to Temporary Total Disability benefits from November 27, 2010 through April 19, 2011, a period of 20 4/7 weeks. The Respondent did not dispute the period of disability but merely its liability for the payment of benefits based upon the disputed issues of accident and causation. As the Arbitrator has found for the Petitioner with respect to those disputed issues, the Arbitrator finds that the Petitioner is entitled to Temporarily Totally Disability benefits from November 27, 2010 through April 19, 2011 for a period of 20 4/7 weeks. The parties stipulated that the Respondent paid the Petitioner $2,777.76 in Temporarily Totally Disability benefits during that time.

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 Arbitrator's findings and conclusions relating to the issues of accident and causation are adopted and incorporated herein.

As a result of the work accident of November 26, 2010, the Petitioner sustained a herniated disc at L5-S1, for which he underwent surgery consisting of an L5-S1 hemilaminotomy with microdiscectomy. The Petitioner was determined to be at maximum medical improvement from his injury as of April 19, 2011 and he was released to return to work without restrictions. The Petitioner testified that he continued to have some back pain following his release and that he currently experiences stiffness in his back after sitting in car for prolonged periods as well as occasional muscle spasms. He testified that he currently takes over the counter pain medications, up to two to three times per week and that he does not feel he is able to lift any more than one hundred pounds.

Based upon the foregoing, and having considered the totality of the credible evidence adduced at hearing, the Arbitrator finds that the Petitioner's injury of November 26, 2010 resulted in permanent disability to the Petitioner's whole person to the extent of 17.5% thereof.

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

Stefanos Vasilakis,

Petitioner,

vs.

No. 12 WC 03441

17IWCC0526

Illinois Secretary of State,

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 medical expenses, prospective medical care, temporary disability, permanent disability, 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 agrees with the Arbitrator's Decision in all respects, except the extent of Petitioner's disability. The Commission agrees with the Arbitrator's determination of how much relative weight to give each of the factors enumerated in section 8.1b(b) of the Workers' Compensation Act (the Act). However, the Commission finds a lesser degree of disability (factor (v)) than the Arbitrator found.

Petitioner claims significant posttraumatic stress disorder (PTSD) after giving a road test to an 88-year-old man, who ended up losing control of the car, crossing into oncoming traffic, stepping on the gas instead of the brake, not following Petitioner's instructions to regain control of the car, running the red light, and finally crossing back into the right lane and hitting a parked car and a tree at fairly high speed. Petitioner did not introduce into evidence any treating medical records, instead relying on his own testimony and the testimony and opinions of his

treating psychologist, Dr. McCarthy, and his second opinion doctor, Dr. Morris. Dr. Morris opined that Petitioner continued to suffer from significant residual PTSD—"anxiety, sometimes to the point of dizziness. The pre-occupation, the separating himself from other people. The not feeling okay driving, and certainly not near where he had been, and the nightmares." Dr. Morris believed Petitioner that he could not hold a job as a result. Dr. Morris had not seen Petitioner since examining him in July of 2013.

Dr. McCarthy testified that Petitioner continued to improve with treatment. Near the time of the arbitration hearing, Petitioner reported getting a normal amount of sleep, although he still had upsetting dreams some nights. Dr. McCarthy was not aware of any limitations on Petitioner's activities of daily living. The depression and anxiety were "a function of circumstances now, and it's more short-lived." Petitioner communicated to Dr. McCarthy that he did not want to return to work until he was made whole. Dr. McCarthy stated Petitioner would be ready to return to work "[i]f the dreams were to remit ***, if he were able to drive comfortably *** and be a passenger comfortably. And if the emotional reactions to distress that comes at him unexpectedly were lessened."

Petitioner testified to driving every day to a store or to church, and recently feeling better about driving or riding as a passenger in a car. Petitioner admitted feeling comfortable riding short distances as a passenger with his elderly mother driving. However, Petitioner testified he did not feel he could return to work. Petitioner also testified he would like to return to his job with Respondent, but Dr. McCarthy had not yet released him to return to work. At the time of Dr. Hartman's section 12 examination, Petitioner felt he could do a desk job, but did not pursue that because Dr. McCarthy had not released him to return to work and he still had nightmares every night. Petitioner confirmed now getting approximately nine hours of sleep a night, although he still had frequent nightmares.

The Commission agrees with the Arbitrator that Petitioner was not malingering. Having carefully considered the entire record and weighed the evidence, the Commission finds the proper measure of disability is 20 percent of the person as a whole.

IT IS THEREFORE ORDERED BY THE COMMISSION that the Decision of the Arbitrator filed December 28, 2016, is hereby modified as stated herein and otherwise affirmed and adopted.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $499.39 per week for a period of 156 2/7 weeks, from April 18, 2012 through April 17, 2015, that being the period of temporary total incapacity for work under §8(b) of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent shall pay to Petitioner the sum of $449.45 per week for a period of 100 weeks, as provided in §8(d)2 of the

Act, for the reason that the injuries sustained caused the permanent disability to the extent of 20 percent 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.

Pursuant to §19(f)(1) of the Act, there shall be no right of appeal as the State of Illinois is Respondent in this matter.

DATED: AUG 24 2017
o-06/29/2017
SM/sk
44

Stephen Mathis

David L. Gore

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

VASILAKIS, STEFANOS
Employee/Petitioner

Case# **12WC003441**

17IWCC0526

ILLINOIS SECRETARY OF STATE
Employer/Respondent

On 12/28/2016, 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 0.66% 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:

5836 BEERMAN PRITKIN MIRABELLI
HOWARD TEPLINSKY
161 N CLARK ST SUITE 2600
CHICAGO, IL 60601

0639 ASSISTANT ATTORNEY GENERAL
CHARLENE C COPELAND
100 W RANDOLPH ST 13TH FL
CHICAGO, IL 60601

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

0499 CMS RISK MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

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

DEC 28 2016

HERALD A. HASSIA, Acting Secretary
Illinois Workers' Compensation Commission

17IWCC0526

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

Stefanos Vasilakis
Employee/Petitioner

v

Illinois Secretary of State
Employer/Respondent

Case # 12 WC 03441

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Jeffrey Huebsch**, Arbitrator of the Commission, in the city of **Chicago**, on **1/27/15, 2/17/15 and 4/17/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0526

FINDINGS
On **1/10/2012**, 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 **$38,952.00**; the average weekly wage was **$749.08**.

On the date of accident, Petitioner was **70** years of age, ***married*** with **0** dependent children.

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

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

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

Respondent is entitled to a credit of **$3,538.42** under Section 8(j) of the Act for medical expenses, per the stipulation of the Parties.

ORDER
Respondent shall pay Petitioner **temporary total disability benefits of $499.39 per week for 156-2/7 weeks, commencing April 18, 2012 through April 17, 2015**, as provided in **Section 8(b) of the Act.**

Respondent shall pay Petitioner **permanent partial disability benefits of $449.45 per week for 125 weeks,** because the injuries sustained caused the **25% loss of the person as a whole,** as provided in **Section 8(d)2 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.

Respondent shall pay Petitioner the compensation benefits that have accrued from January 10, 2012 through April 17, 2015, and shall pay the remainder of the award, if any, in weekly payments.

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

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

Signature of Arbitrator

December 28, 2016
Date

DEC 2 8 2016

INTRODUCTION

Petitioner claims that he suffers from Post-Traumatic Stress Disorder as a result of a work related accident. This matter was tried over three days, with the live testimony of three psychologists being submitted at the first and second hearings (Drs. Jeri Morris, Ph.D. and Martin McCarthy, Ph.D. for Petitioner, Dr. David Hartman, Ph.D. for Respondent) and the testimony of Petitioner being taken on the first and third hearing dates.

The issues in dispute were: Accident (Respondent disputed that Petitioner sustained accidental injuries as to the alleged PTSD condition); Causal Connection; Medical Expenses; TTD (Petitioner claiming benefits from 1/19/2012 to present, 162 weeks); Nature and Extent and Penalties (§19(k)). (ArbX 1)

FINDINGS OF FACT

Petitioner was employed by Respondent as a Public Service Representative (PSR) since January of 2005, working at Respondent's Elston Avenue facility in Chicago. His job responsibilities included processing driver's licenses and identification cards, taking photographs, processing paperwork and giving road tests. Apparently, Petitioner gave a lot of road tests to senior drivers, as he was 70 years old at the time of the accident. Before working for Respondent, Petitioner worked for Brach's Candy Co., on the west side of Chicago, for close to 40 years. He started as a cold operator, worked as a machine operator, and was a production supervisor for 30 years.

Petitioner was born in Greece and emigrated to the United States at age 19. He obtained his US citizenship in 1964. He considers Greek to be his first language. At Brach's, Petitioner was supervising 200 to 250 employees. Petitioner aided management at Brach's by helping to communicate with Greek speaking employees.

While Petitioner was working at Brach's, he was involved in a car versus pedestrian accident. Petitioner was hit by a car and flew through the air. He suffered a closed head injury and developed Post Traumatic Stress Disorder (PTSD). Petitioner returned to work about 6 months after that accident. He had treatment for the PTSD condition for about 1 ½ to 2 years by Dr. Nicholas Dunkas, a psychiatrist. Neither Party submitted records from Dr. Dunkas. Petitioner had a law suit against the driver of the car that hit him.

When Petitioner was five years old and living in Greece, his father was killed in a truck accident while serving in the military.

Petitioner testified that he liked his job as a PSR. He testified on direct examination that he took no vacation or sick days and only three personal days off. This testimony was later retracted and was shown to be false by attendance records. (RX 5)

On January 10, 2012, Petitioner was injured in a car accident while working as a PSR. He was giving an elderly man a road test (sitting in the passenger side of the car) and the elderly driver lost control of his car. Initially, the driver was doing well with the road test. When the car turned onto Central Avenue, the elderly driver crossed the center lane and drove into oncoming traffic. He accelerated. He did not go

back in the right lane. He said that he could not use the brakes. A big yellow truck was heading towards the car. The truck moved right to avoid a collision and drove up on the sidewalk. The car was going 40 or 50 miles per hour in a 30 mph zone. The car went through a red light. The car went back in the right lane and hit a parked car on the driver's side of the parked car with the passenger side of the elderly man's car. Petitioner was sitting on the passenger side when it struck the parked car. The elderly man's car continued, hitting a no parking sign and coming to a rest against a tree. Petitioner testified that he could not grab the steering wheel or do anything to stop the car. The police were called and Petitioner was eventually taken back to Respondent's facility. The elderly driver did not pass the road test.

Petitioner testified that he felt neck pain and low back pain after the accident. He did not seek immediate medical care.

Back at Respondent's facility, Petitioner advised his supervisors, about the accident. He went to the locker room for about 45 minutes and then worked the rest of the day. He did one incomplete road test and then sat on a chair waiting for contact with his managers. The managers never checked on Petitioner's well-being. Petitioner worked the rest of his scheduled work week, taking pictures and processing paperwork. He did not do any road tests.

Petitioner's last date of work was January 19, 2012. Petitioner testified that the accident occurred on Monday, January 10, 2012. The Arbitrator's calendar shows that January 10, 2012 was a Tuesday.

Petitioner continued to experience neck and back pain. He called his PCP, Dr. Karabelas, but the doctor was on vacation. Petitioner was advised to take a warm bath. Eventually, Petitioner was seen by Dr. Karabelas for his back and neck complaints. Petitioner testified that Dr. Karabelas recommended physical therapy, which took place at Accelerated for 7 months. Petitioner testified that he began having dreams, re-experiencing the road test and the accident, nightly. The dreams obviously troubled Petitioner. Petitioner requested medication from Dr. Karabelas. Dr. Karabelas recommended a psychiatrist, Dr. DeCastro. Neither Party submitted the records of Dr. Karabelas, or of Accelerated.

Petitioner was unable to set an appointment with Dr. DeCastro, so he called Dr. Dunkas, who had previously treated Petitioner for PTSD following the car versus pedestrian accident in the 1980's. Dr. Dunkas was winding down his practice, so he referred Petitioner to Dr. Peter Hsin, who provided psychiatric care and prescribed Setraline and Quitapine. Dr. Hsin continues to provide Petitioner with psychiatric care. Petitioner began treatment with Dr. Hsin in the beginning of March of 2012. Neither Party submitted the records of Dr. Hsin.

Dr. Hsin referred Petitioner to Dr. Martin McCarthy, Ph.D. for psychologist follow-up care. The first treatment by Dr. McCarthy was on April 18, 2012. Dr. McCarthy's opinion is that Petitioner has severe emotional distress, Post-Traumatic Stress Disorder, major depressive disorder, anxiety and depression. Dr. McCarthy recommended that Petitioner not return to work at Respondent and instituted a plan of care involving: 1.) Prolonged exposure therapy; 2.) Systematic desensitization; and 3.) relaxation techniques. Petitioner has made progress, but is not yet at MMI. Dr. McCarthy does not believe that Petitioner is feigning his symptoms. Dr. McCarthy believes that Petitioner's current problems, including PTSD, are causally related to the accident of January 10, 2012. Petitioner has not been released to return to work by Dr. McCarthy, yet. (PX 3, 4 & 5)

Neither Party submitted any evidence that Petitioner was medically authorized off work before Dr. McCarthy recommended no work on April 18, 2012.

Dr. McCarthy referred Petitioner to Dr. Jeri Morris, Ph.D. for a second opinion and to rule out malingering (Respondent's §12 examiner, Dr. Hartman had diagnosed malingering in his May 13, 2013 report, discussed below). Dr. Morris was on staff at RIC for a number of years and dealt with many cases of PTSD. The stated purpose for her examination of Petitioner was to determine what, if any, psychological sequelae Petitioner had as a result of the January 10, 2012 MVA. Dr. Morris was of the opinion that Petitioner is genuine and suffering from PTSD and it is causally related to the accident. The accident probably reignited the prior PTSD condition. Petitioner is not malingering. (PX 1 & 2)

Petitioner was never paid TTD benefits. He used vacation, sick days and PTO days. Petitioner contacted Springfield on several occasions, sometimes in the presence of Dr. McCarthy, regarding benefits. Petitioner was told that his claim involved "non-service" disability. He was later told that his claim was being reclassified as workers' compensation. There was no evidence that the claim was reclassified as workers' compensation. Respondent did not submit any evidence of its compliance with Rule 7110.70.

Respondent had Petitioner examined by a psychologist, Dr. David Hartman, Ph.D., on May 13, 2013. The reason for the referral to Dr. Hartman was to provide a diagnosis, advise whether the anxiety and PTSD were causally related to the accident and to comment on MMI and return to work. Dr. Hartman did not support a diagnosis of PTSD. He thought that Petitioner was feigning chronic anxiety and PTSD. Petitioner's motivation for malingering was that he wanted to retire and was angry at Respondent for not helping him after the accident. Petitioner does not have the constellation of symptoms that would be consistent with PTSD. He does not have the life impairment which would be expected with the diagnosis of PTSD. Dr. Hartman did not think that the MVA caused by the erratic driving senior was shocking enough to trigger PTSD. Petitioner did not exhibit emotional numbing and withdrawal that is expected in PTSD patients. Dr. Hartman's opinions were as of the date of exam. Dr. Hartman had no opinion as to whether Petitioner had an acute or temporary case of PTSD prior to the date that he examined Petitioner. (RX 1 & 2)

Dr. Hartman authored a report, dated February 12, 2014, rebutting the opinions of Drs. Morris and Dr. McCarthy. He criticized their testing methodology and maintained that Petitioner was malingering. Petitioner wants to retire. He disputes all efforts to return to work. There is no objective rationale for continued psychiatric treatment or psychotherapy. Petitioner is capable of full duty work. (Rx 4)

Petitioner testified that he wanted to return to work. He will do so when he is released by Dr. McCarthy. Dr. McCarthy does not support return to work at Respondent at this time. Petitioner's condition could worsen as a result. No evidence was submitted about any efforts by Petitioner to return to work anywhere. Respondent did not provide any evidence of trying to facilitate a return to work by Petitioner, other than the suggestions by Dr. Hartman that were resisted by Petitioner in their session.

Petitioner denied telling Dr. Hartman that he wanted to retire. While Dr. Hartman testified that Petitioner said that Dr. McCarthy would "wash his hands of him" if he returned to work at Respondent, Petitioner said that Dr. McCarthy told him that if he returned to work, it would be against his advice. Petitioner rode as a passenger in a car with his 89 year-old mother driving. Petitioner drives himself. He experiences fear around big trucks. Petitioner testified that his son and granddaughter call him nightly. Later, Petitioner testified that he has no grandchildren. According to Dr. Hartman, Petitioner denied prior psychiatric treatment.

CONCLUSIONS OF LAW

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

To obtain compensation under the Act, Petitioner has the burden of proving, by a preponderance of the evidence, all of the elements of his claim (O'Dette v. Industrial Commission, 79 Ill. 2d 249, 253 (1980)), including that there is some causal relationship between his employment and his injury. Caterpillar Tractor Co. v. Industrial Commission, 129 Ill. 2d 52, 63 (1989) Decisions of an arbitrator shall be based exclusively on evidence in the record of proceeding and material that has been officially noticed. 820 ILCS 305/1.1(e)

WITH RESPECT TO ISSUE (C), DID AN ACCIDENT OCCUR THAT AROSE OUT OF AND IN THE COURSE OF PETITIONER'S EMPLOYMENT BY RESPONDENT, THE ARBITRATOR FINDS AS FOLLOWS:

Petitioner sustained accidental injuries which arose out of and in the course of his employment by Respondent on January 10, 2012, based upon the unrebutted testimony of Petitioner. Respondent disputes that the accident resulted in any PTSD condition (causation?), but that is no basis for disputing accident in this case, as the Petitioner testified that he suffered neck and back pain after the accident, for which he underwent treatment by his PCP, including PT at Accelerated.

The Arbitrator further finds that Petitioner experienced sudden, severe emotional shock that produced a psychological injury, or psychological harm, as a result of the MVA that occurred on January 10, 2012 while he was working as a PSR. Petitioner's testimony regarding the accident was credible and the event was more than an everyday fender bender type car accident that drivers experience commonly. See: Diaz v. Illinois Workers' Compensation Comm'n, 2013 IL App (2d) 120294WC

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

It has long been recognized that, in pre-existing condition cases, recovery will depend on the employee's ability to show that a work related accident aggravated or accelerated the preexisting disease such that the employee's current condition of ill being can be said to have been causally connected to the work-related injury and not simply the result of a normal degenerative process. Sisbro, Inc. v. Indus. Comm'n, 207 Ill.2d 193, 204-05, (2003). It is axiomatic that employers take their employees as they find them; even when an employee has a pre-existing condition which makes him more vulnerable to injury, recovery for an accidental injury will not be denied as long as it can be shown that the employment was a causative factor. Id. 207 Ill.2d at 205. An employee need only prove that some act or phase of his employment was a causative factor of the resulting injury, the mere fact that he might have suffered the same disease, even if not working, is immaterial. Twice Over Clean, Inc. v. Indus. Comm'n, 214 Ill.2d 403, 414, (2005).

Three expert witnesses with outstanding credentials testified in this case. Post-Traumatic Stress Disorder cases are complicated and tough from both a psychiatric and a legal perspective.

If Respondent's forensic expert is to be believed, Petitioner is a faker who is not suffering from PTSD, is at MMI and is capable of returning to work for Respondent at full duty as a PSR at Respondent's Elston Avenue facility. Petitioner's motivations for malingering are that he wants to retire and he does not feel that Respondent treated him fairly after the accident. It is to be noted that Dr. Hartman's opinions are as of May 13, 2013. He does not have an opinion as to whether Petitioner had some acute or temporary PTSD condition after the accident and before May 13, 2013. The PTSD condition was not present on the day that Dr. Hartman examined Petitioner.

If Petitioner's experts are to be believed, Petitioner is not a faker –he has severe emotional distress due to PTSD, which is causally related to the accident. Petitioner is not capable of returning to work at Respondent and is in need of weekly psychotherapy sessions.

Dr. McCarthy was a treating psychologist and he does seem to be genuine and concerned regarding Petitioner's condition. This was the first time that Dr. McCarthy testified in a case. Dr. McCarthy's opinions are credible and persuasive as to causation and Petitioner's current condition of ill-being. Dr. McCarthy believes that Petitioner has PTSD related to the accident and is not malingering.

Dr. Morris was retained by Dr. McCarthy to render a second opinion in light of Dr. Hartman's opinion that Petitioner did not have PTSD and was malingering. Dr. Morris' opinions on causation and Petitioner's current condition of ill-being are credible and persuasive. Dr. Morris believes that Petitioner has PTSD related to the accident and is not malingering.

Dr. Hartman's opinions are not persuasive in this case. He appears to have evaluated Petitioner primarily for malingering, as opposed to whether the patient had PTSD, even though Dr. Hartman did opine that Petitioner did not have PTSD as of the May 13, 2013 exam. Dr. Hartman could not rule out acute or temporary PTSD from the event that had resolved. His theory that the accident was not sufficiently horrifying ("an unpleasant event") to have triggered PTSD in this patient is not persuasive in this case. Further, Petitioner's testimony that he liked his job is unrebutted. Dr. Hartman's theory that Petitioner wanted to retire is not supported by any other evidence. Respondent did not bring in witnesses to dispute that Petitioner enjoyed working, or to testify that he wanted to retire. The Arbitrator believes that Petitioner would still be working as a PSR if the accident did not occur and he was physically able to do so.

The Arbitrator observed the demeanor and testimony of Petitioner and finds Petitioner to be a credible witness. There are some inconsistencies in Petitioner's testimony and it does appear that the accident did not lead to complete emotional numbing and withdrawal by Petitioner (he has a good family relationship, he could be a passenger when his elderly mother drove), but the Arbitrator finds the opinions of Drs. McCarthy and Morris on causation, as to the PTSD diagnosis and that Petitioner is not malingering to be correct. The Arbitrator believes Petitioner's testimony that if Dr. McCarthy released him to return to work, he would.

Petitioner's current condition of ill-being, Post-Traumatic Stress Disorder and related psychologic conditions as described by Dr. McCarthy, is causally related to the accidental injuries of January 10, 2012.

WITH RESPECT TO ISSUE (J), WERE THE MEDICAL SERVICES THAT WERE PROVIDED TO PETITIONER REASONABLE AND NECESSARY AND HAS RESPONDENT PAID ALL APPROPRIATE CHARGES FOR ALL REASONABLE AND NECESSARY MEDICAL SERVICES, THE ARBITRATOR FINDS AS FOLLOWS:

No medical bills were submitted into evidence and, therefore, none are awarded.

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

Petitioner claimed TTD from January 19, 2012 to present. Petitioner has the burden of proving that he is entitled to an award of TTD benefits. He must not only show that he did not work, but that he was unable to work. Pietrzak v. Industrial Comm'n, 329 Ill. App. 3d 828, 832 (2002). The first medically authorized lost time that is supported by the evidence adduced begins on April 18, 2012, when Dr. McCarthy recommended that Petitioner be off work. Dr. McCarthy endorsed that Petitioner was disabled from work at the time of his testimony in this case (January 27, 2015). Petitioner testified that he had not yet been released to return to work as of April 17, 2015, the date of the last hearing in this case.

Based upon the Arbitrator's findings above regarding accident and causation, Petitioner is entitled to TTD benefits from April 18, 2012 through April 17, 2015, a period of 156-2/7 weeks. See: Interstate Scaffolding, Inc. v. Illinois Workers' Compensation Commission, 236 Ill.2d 132 (2010)

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

The Parties stipulated that the nature and extent of the injuries was in dispute.

Pursuant to §8.1b of the Act, the following criteria and factors must be weighed in determining the level of permanent partial disability for accidental injuries occurring on or after September 1, 2011:

(a) A physician licensed to practice medicine in all of its branches preparing a permanent partial disability impairment report shall report the level of impairment in writing. The report shall include an evaluation of medically defined and professionally appropriate measurements of impairment that include, but are not limited to: loss of range of motion; loss of strength; measured atrophy of tissue mass consistent with the injury; and any other measurements that establish the nature and extent of the impairment. The most current edition of the American Medical Association's "Guides to the Evaluation of Permanent Impairment" shall be used by the physician in determining the level of impairment.

(b) In determining the level of permanent partial disability, the Commission shall base its determination on the following factors:

(i) the reported level of impairment pursuant to subsection (a);
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

No single enumerated factor shall be the sole determinant of disability. In determining the level of disability, the relevance and weight of any factors used in addition to the level of impairment as reported by the physician must be explained in a written order.

With regard to subsection (i) of §8.1b(b), the Arbitrator notes that no permanent partial disability impairment report and/or opinion was submitted into evidence. Therefore, this factor is given no weight in determining PPD.

With regard to subsection (ii) of §8.1b(b), the occupation of the employee, the Arbitrator notes that the record reveals that Petitioner was employed as a PSR at the time of the accident and that he was not able to return to work in his prior capacity as a result of said injury, as of the time of trial. The Arbitrator gives this factor great weight in determining PPD.

With regard to subsection (iii) of §8.1b(b), the Arbitrator notes that Petitioner was 70 years old at the time of the accident. This factor is given some weight in determining PPD because Petitioner may have some difficulty in finding suitable employment, given his age and the limitations of the effects of his injury.

With regard to subsection (iv) of §8.1b(b), Petitioner's future earnings capacity, the Arbitrator notes that given Petitioner's age, experience and the limitations due to the effects of the injury, his future earnings capacity may be significantly limited. This factor is given moderate weight in determining PPD.

With regard to subsection (v) of §8.1b(b), evidence of disability corroborated by the treating medical records, the Arbitrator notes that Dr. McCarthy documents significant limitations in Petitioner's functioning due to the effects of the injury, this is corroborated by the testimony of Dr. Morris. This factor is given significant weight in determining PPD.

Based on the above factors, and the record taken as a whole, the Arbitrator finds that Petitioner sustained permanent partial disability to the extent of 25% loss of use of the 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:

At trial, Petitioner sought Penalties, pursuant to §19(k) of the Act. Petitioner did not claim §19(l) penalties or §16 attorney's fees.

Respondent did not show compliance with Rule 7110.70, so a strong argument can be made for §19(l) penalties. The Arbitrator declines to award §19(l) penalties or §16 attorney's fees because the same were not requested at the time of trial.

The Arbitrator declines to award §19(k) penalties, due to the complex medical and legal issues in this case. Respondent's failure to pay compensation is not found to be unreasonable, or in bad faith.

The Parties are reminded to provide Petitioner's prior counsel, George L. Tamvakis, with a copy of this Decision.

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

Joseph Kinder,

Petitioner,

vs. NO. 13WC 22959

Elite Staffing

Respondent.

17IWCC0527

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, causal connection, mileage, 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 March 2, 2016 is hereby affirmed and adopted.

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

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

17IWCC0527

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $27,300.00. 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 24 2017

Stephen J. Mathis

SJM/sj
o-8/3/2017
44

David L. Gore

DISSENT

I would reverse the Decision of the Arbitrator as Petitioner failed to prove he sustained accidental injuries arising out of his employment on April 17, 2013. I do not find Petitioner to be credible. Petitioner contradicted himself as to what he was doing when he was injured, where he was when he was injured, and how the injury happened. Furthermore, Petitioner was not truthful with medical providers when he denied any history of back injuries or treatment.

Petitioner's alleged accident occurred on his second day of employment. He testified that at the time of the accident he was working on the assembly line packing erasers into boxes, taping the boxes, and then loading the boxes onto a pallet. On further questioning, Petitioner insisted that he personally performed each duty on the line of production. He testified that the packed boxes weighed approximately one pound. Petitioner testified that he started work at 8:00 a.m. and the accident occurred in the early afternoon. He testified that when he twisted to the left to put a box down on the pallet his legs gave out and landed on a table "full force." He testified that he went down to the floor and was unable to stand, his back went numb, and he had pain in the left side and going down both legs. No witnesses to the accident were presented at trial.

Petitioner's supervisor, Ms. Dallas, testified that there was no way Petitioner could have done all of jobs on the assembly line as he had testified, "[Y]ou can't fill the boxes running 15 to 20 pieces a line [per minute], tape it and run down and put it on a pallet." Ms. Dallas testified that Petitioner's assigned position was in front of the tape machine, not at the end of the line where Petitioner testified to having sustained the injury. Furthermore, Ms. Dallas testified that Petitioner could not have been at the pallet when he collapsed on the table, as the table was 10 to 15 feet away from the pallet.

On rebuttal, Petitioner revised his testimony. He testified that in the morning he was filling the boxes, but he got into "an altercation" with a supervisor who said he was too slow and moved him to the end of the line to stack boxes onto the pallet. Petitioner testified that he was stacking boxes for about an hour when the accident happened. This is inconsistent with Petitioner's earlier testimony and his accident report. Petitioner completed an accident report

17IWCC0527

stating that he was loading boxes into the tape machine when the accident occurred: "was standing on Line C loading boxes into the tape machine turned to the left and dropped caught table to hold myself up tried to stand by letting go and fell against table." Respondent's exhibit 18 depicts the assembly line, and the table is shown at the middle of the line and not at the end. Both Petitioner and Ms. Dallas testified that RX18 is an accurate representation of the assembly line.

Petitioner also lied to medical providers about previous back injuries and treatment. Medical records in evidence document previous complaints and treatment for his back. On January 8, 2012, Petitioner sought emergency treatment for complaints of low back pain and reported that he had previous similar episodes. Petitioner was diagnosed with acute muscular spasm. The records of Multi-Care Specialists show that Petitioner treated with a chiropractor for neck and left-sided low back pain from September through December of 2012. At his last visit at Multi-Care Specialists at the end of 2012 he continued to have low back soreness. However, when examined by Dr. Coyle on June 4, 2013 he denied any history of back injuries or treatment. When confronted at trial, Petitioner testified that he had misunderstood the question of whether he had any prior back treatment. He testified that he had prior episodes of "skeletal muscle" pain and sustained a fall "years ago."

Petitioner did not return to work for Respondent and sought employment as a truck driver. Employment records for C.R. England revealed that Petitioner underwent a Physical Agility Test on January 19, 2014. He passed the testing and was certified. The records also include a medical questionnaire filled out by Petitioner where he checked a box signifying that he had no spinal injury or disease, nor did he have chronic low back pain, nor did he have any injuries within the last 5 years. At trial, Petitioner agreed that he did not tell the DOT examining physician about his history of back problems or the ongoing pain he alleges in relation to the April 17, 2013 accident.

I would find that Petitioner's testimony was not credible and was not supported by the evidence. Respectfully, I dissent from the majority opinion affirming and adopting the Decision of the Arbitrator.

Deborah L. Simpson

Deborah L. Simpson

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

KINDER, JOSEPH
Employee/Petitioner

Case# **13WC022959**

ELITE STAFFING
Employer/Respondent

17IWCC0527

On 3/2/2016, 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 0.48% 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
DAVID J JEROME
5440 N ILLINOIS ST SUITE 101
FAIRVIEW HEIGHT, IL 62208

2396 KNAPP OHL & GREEN
DAVID GREEN
6100 CENTER GROVE RD
EDWARDSVILLE, IL 62025

17IWCC0527

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

Joseph Kinder
Employee/Petitioner

v.

Elite Staffing
Employer/Respondent

Case # **13** WC **022959**

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 **12/21/15**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

FINDINGS

On **4/17/13**, Respondent *was* operating under and subject to the provisions of the Act.

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

On this date, Petitioner *did* 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 $**103.13 over 2/5 weeks**; the average weekly wage was $**257.83**.

On the date of accident, Petitioner was **45** 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 $**421.90** for TTD, $**0** for TPD, $**0** for maintenance, and $**0** for other benefits, for a total credit of $**421.90**.

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

ORDER

Respondent shall pay temporary total disability benefits of $220.00/week for 20-6/7 weeks commencing 4/17/13 through 9/9/13, as provided in Section 8(b) of the Act.

Respondent shall pay reasonable and necessary medical services of $20,171.53, pursuant to the medical fee schedule, as provided in Section 8(a) and 8.2 of the Act.

Respondent shall be given a credit of $1,911.04 for medical benefits that have been paid.

Respondent shall pay Petitioner permanent partial disability of $220.00 per week for 20 weeks because the injury sustained caused 4% loss of the loss of the body as a whole, as provided in Section 8(d)(2) of the Act.

Respondent shall pay mileage of $28.36 (50.2 miles x .565).

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

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

Edward Lee
Signature of Arbitrator

2/8/16
Date

ICArbDec p. 2

MAR 2 - 2016

Joseph Kinder v. Elite Staffing
#13 WC 022959

Statement of Facts:

Petitioner Joseph Kinder began working full-time for Elite Staffing on April 16, 2013. (Tr.11). He was assigned an assembly line position at Proctor & Gamble. (Tr.11-12). Petitioner's job duties included filling boxes with Magic eraser sponges, taping the box closed and placing the filled box on a pallet on the floor. (Tr.12). The filled boxes weighed one to two pounds. Petitioner's job required that he repetitively bend and twist either obtaining boxes from the table behind the assembly line or in placing the boxes onto the pallet located on the floor. (Tr.13).

On April 17, 2013, Petitioner started the day at 8:00 a.m. in the middle of the assembly line filling and taping boxes. However, he was switched in the afternoon by his supervisor to the end of the line stacking boxes. (Tr.115). Petitioner testified that he had been moved to the end of the line because he could not keep up with the pace in the middle of the line as he was too slow. The end of the assembly line required that Petitioner unload boxes from the assembly line to the pallet on the floor. Unloading the boxes required that Petitioner repetitively bend and twist in order to remove them from the assembly line and then stack the boxes to his left on the floor.

While performing these activities, Petitioner developed low back pain, his legs went numb, and he fell forward. (Tr.17). Petitioner testified that he tried to stand up but was unable to do so. (Tr.17). Petitioner felt that it was the repeated twisting that caused the problems and not the weight of the box itself. (Tr.17-18). Petitioner testified that he felt sharp pain on his lower left side going down both legs that caused him to lose feeling in his left leg and develop symptoms in his low back. (Tr.17).

Petitioner testified that a supervisor and a co-worker came to his aid. (Tr. 19). Petitioner testified that he advised his supervisor of the twisting event and was taken by ambulance to Gateway Regional Medical Center Emergency Room. (Tr.19-20). Petitioner testified that when he went to Gateway, he advised them of the same history that he advised his supervisor as well as the court Arbitrator at trial.

Medical records from Gateway Regional Medical Center confirm Petitioner's testimony. The emergency room doctor recorded, "45 year old male presents from work injury to left low back. Patient states he was lifting one pound boxes at work and twisted when he noticed sharp pain in his low back. He fell to the ground and was unable to stand on his own. He was helped to his feet but the pain did not go away." (Px.2).

Petitioner testified that following the emergency room visit, he was provided work restrictions and was advised to follow up with his family doctor. (Tr.20-21). Petitioner attempted to follow up with his family doctor, Dr. Lupardus, but was advised by his employer that instead he was being sent to Gateway Occupational Medicine. (Tr.21). Petitioner was not given the option of being able to see his own doctor. (Tr.21-22).

Petitioner provided the similar history to the doctors at Gateway Occupational Medicine. Medical records from Gateway Regional Occupational Health Services, dated April 22, 2013, confirm Petitioner's testimony. Dr. Kibby at this facility recorded, "The patient just started

working for Elite Staffing in a Proctor & Gamble warehouse where he is working on the production line, doing a lot of twisting and lifting of a very light box as he estimates probably weighed less than one pound when he felt onset of pain in his left lumbar region with all the twisting." (Px.3). Following examination, Dr. Kibby diagnosed an acute lumbar strain; placed Petitioner on modified duty; recommended physical therapy; and provided pain medications as well as muscle relaxers. (Px.3).

Thereafter, Petitioner completed physical therapy at the same facility that was fully approved by the workers' compensation carrier. Petitioner testified that while on light duty, his employer was unable to accommodate the work restrictions and therefore he was paid lost time benefits for this duration although the weekly rate varied dramatically.

On May 17, 2013, Petitioner was referred by Dr. Kibby for an MRI that was completed at Gateway Regional Medical Center. The MRI diagnosed two protruding discs at L4-5 and L5-S1. Following the MRI, Dr. Kibby referred Petitioner to an orthopedic spine surgeon for surgical consideration. (Tr. 21) (Rx.3).

In response, Respondent sent Petitioner to Dr. James Coyle. (Tr. 26-28). Petitioner testified that he was advised by way of a phone call from the workers' compensation adjuster to see Dr. Coyle. (Tr.28). Petitioner testified that although he went to Dr. Coyle's appointment as requested, he was never paid mileage. Petitioner entered into evidence a mileage chart showing that he had traveled 50.2 miles to travel to and from Dr. Coyle's office. (Px.11).

Petitioner testified that Dr. Coyle spent approximately 30 minutes with him discussing the nature of the injury. (Tr.29). Petitioner testified that he had described to Dr. Coyle the twisting episode similar to what he had discussed with the emergency room as well as Gateway Occupational Medicine. In spite of this, Dr. Coyle recorded that Petitioner put a one pound box into a tape machine when his legs gave out on him. (Tr.29-30) (Rx.1). Petitioner testified that that is not the complete history that he had provided to Dr. Coyle as it did not include the twisting. (Tr.30). Dr. Coyle recommended injections into his low back and physical therapy. Dr. Coyle also provided work restrictions as well as a script to see a pain management specialist. (Tr.30) (Rx.1).

Petitioner tried to treat with Dr. Coyle but Respondent would not authorize treatment nor would they allow Petitioner to treat with a pain management specialist recommended by Dr. Coyle. (Tr.31). Additionally, Petitioner was provided light duty restrictions by Dr. Coyle which his employer was unwilling to accommodate. In spite of this, Respondent stopped all lost time benefits.

After being refused further treatment by the workers' compensation carrier, Petitioner followed up with Dr. Eavenson at Multicare Specialists on July 2, 2013. (Tr.33) (Px.5). Petitioner provided a similar history to Dr. Eavenson that he had provided to all of the prior doctors. Dr. Eavenson records, "The patient returns to the office today with low back pain and pain into his extremities, the left leg worse than the right leg. He states this began on April 17, 2013 while working for Proctor and Gamble. His job consists of constantly picking up and moving 10 pound boxes, this also involves a significant amount of twisting and bending. He states on this particular day, that both of his legs went weak and gave out on his about two hours

prior to the end of the shift. He had to be taken by wheelchair to the office until an ambulance arrived." (Px.5). Following the initial evaluation, Dr. Eavenson prescribed and completed physical therapy at his facility. Eventually, Dr. Eavenson referred Petitioner over to Dr. Blake for injections. (Tr.24) (Px.5).

Thereafter, Petitioner underwent roughly six injections with Dr. Blake with the last one occurring in January of 2014. (Tr.34) (Px.6). Petitioner testified that the injections helped to reduce the symptoms in his low back as well as remove the symptoms going down his left leg. (Tr.35). Petitioner testified that when he last saw Dr. Blake in January of 2014, he believed that she had placed him at maximum medical improvement but advised him that he could come back if he had any further problems.

While he was receiving treatment with Dr. Eavenson and Dr. Blake, Petitioner was continued on a light duty status until September 9, 2013. However, during this time period, he was not paid any lost time benefits. Petitioner was released to return to work full duty on September 9, 2013.

Thereafter, Petitioner returned to work as a truck driver at Spirit Miller, a transportation company hauling new trucks. (Tr. 37). Petitioner testified that this was the first time he had returned to work following his release to return to work full duty. (Tr.38). Petitioner testified that he drove for Spirit Miller for approximately one month and then moved to Quality Transportation where he continued to work full time as a truck driver. Thereafter, he moved to CR England Global Transportation. (Tr.39). Petitioner testified that he worked for CR England for approximately 1-1/2 years where he worked full duty with no restrictions. Petitioner testified that he was able to do this job as he did not do any loading or unloading. (Tr.45).

Petitioner testified that before beginning work at CR England, he completed a DOT physical examination on January 19, 2014. Petitioner had just completed an injection with Dr. Blake three days prior and therefore as of the date of the examination, his back was doing fine as he had just had the injection. (Tr.46). Petitioner testified that at the time he completed the form regarding the DOT physical examination, he did not believe that he was having any chronic low back pain as he was not having symptoms every day, seven days a week. (Tr.47). Petitioner admitted that he did check the wrong box by mistake when it asked whether he had had any injury in the last five years. (Tr.48). Petitioner did not believe that he was lying to the examiner but simply made a mistake. (Tr.48).

Petitioner testified that he is currently working for Roll On Transportation as a truck driver. He still has no work restrictions and has been able to complete his work activities on a full-time basis. (Tr.49). Petitioner testified that he has not sought any treatment since January of 2014 relative to his low back. (Tr.49-50). Petitioner testified that he did see Dr. Paul Pace for an appendectomy and advised the doctor that he was having some low back pain but was not prescribed any further treatment relative to his low back. (Tr.49-50).

Petitioner testified that since this low back injury of April 17, 2013, he has not sustained any new injuries to his low back. (Tr.50). Prior to the work injury, Petitioner sustained some musculoskeletal injuries to his low back. In January of 2012, Petitioner injured his low back and went to the emergency room for a single visit. (Tr.51). Petitioner testified that at that time, Dr.

Eavenson was his family doctor and if he had any ongoing low back problems, he would have followed up with Dr. Eavenson. (Tr.51-52). Petitioner testified that during this time, he treated with Dr. Eavenson for other health issues but was not having any low back problems.

Again in September of 2012, Petitioner had a flare-up of musculoskeletal low back issues. He treated with Dr. Eavenson for low back and neck issues between September of 2012 and December of 2012. (Tr.52) (Px.5). Dr. Eavenson ordered and completed an MRI of the neck in September of 2012 but never requested an MRI of his low back. (Tr.52-53). (Px.5). Petitioner testified that the first time that anyone had recommended an MRI of his low back was following this work injury. (Tr.53)

Petitioner testified that symptoms down his left leg did not begin until the work injury. (Tr.53). Treatment records from Dr. Eavenson confired that Petitioner did not complain of any radicular symptoms down the left leg until after the work injury. Similarly, the medical records from Dr. Eavenson confirmed Petitioner's testimony that no doctor had never referred him for an orthopedic evaluation; never recommended any type of injections; and never recommended any form of pain management until after the work injury. (Tr.53-54) (Px. 5).

Petitioner testified that when Dr. Eavenson released him in December of 2012, he was having no low back problems. Medical records from Dr. Eavenson confirm that doctor did not provide Petitioner with any ongoing work restrictions or ongoing pain medications.

In addition to treating with Dr. Eavenson prior to the work injury, Petitioner also saw his family doctor, Dr. Bell, for other health conditions. Petitioner testified that if he was having ongoing problems with his low back, he would have advised Dr. Bell during the visits that he had with him leading up to the work injury. (Tr.54). Dr. Bell's medical records contain no complaints of low back problems leading up to the work injury.

At trial, Petitioner continued to have pain in his low back on the lower left side. He rated his pain as uncomfortable at a 2 out of 10. Petitioner takes Ibuprofen on an occasional basis to help to reduce the symptoms. (Tr.56). Petitioner also purchased a new bed that he believes has helped to reduce the symptoms in his low back. (Tr.57). Petitioner testified that the medical care with Dr. Eavenson and Dr. Blake helped to reduce the symptoms and remove the symptoms going down his left leg. (Tr.57).

On cross-examination, Petitioner testified that when he underwent the DOT physical examination, the doctor examined his low back. Petitioner testified that he was uncertain as to why the DOT mentions strenuous exercise including weight lifting as Petitioner testified that he does not weight lift or even belong to a gym. Similarly, Petitioner testified that as part of his job duties as a truck driver, he did not do any lifting but he did have to be able to climb in and out of semi-trucks. (Tr.89).

On re-direct, Petitioner testified that prior to the work injury, he had sustained musculoskeletal injuries but none of them involved pain going down his left leg. (Tr.98). The symptoms were never severe to the point that they lingered until this work injury. (Tr.98).

Jessica Dallas testified on behalf of Elite Staffing. Dallas was the site supervisor at the Proctor & Gamble building where Petitioner worked. Dallas testified that she was not present at the time of Petitioner's accident and did not see it occur. (Tr.101). Dallas testified that she saw Petitioner earlier that day working on the assembly line. She noted as she was getting ready to leave on the date of the accident, she noted that he was being wheeled out into the office. (Tr.101-102).

Dallas testified that while she wasn't there at the time of the accident, it was her belief that Petitioner was standing before the tape gun in between the boxes and the rollers. (Tr.103). Dallas testified that she believed that Petitioner's job involved taking the empty box from the table behind the assembly line; putting the tray of sponges into the empty box; closing both ends of the box; and running the box through the tape machine. (Tr. 104). Dallas noted that the line would process between 15 to 20 boxes per minute.

Dallas testified that the taped boxes continue down to another set of rollers to a pallet where they were then unloaded onto the pallet on the floor. (Tr.104-105). Dallas testified that there would be no reason to twist the body as you would have to grab a box with one hand and the other hand to pull it in the tray and run it through the tape machine. She saw no reason for him twisting. (Tr.105-106).

On cross-examination, Dallas admitted that at the end of the line, the pallet would have been on the floor next to the conveyor line. However, she noted that if an individual was taking boxes was off the line, she did not believe that they would twist. Instead, she testified that a person would move his feet and not twist his body to place the boxes from the conveyor belt onto the pallet. (Tr.109).

Dallas testified that she was not aware as to whether Petitioner had been moved to the end of the line where he would have put boxes onto a pallet. (Tr.110). It was her belief that his job involved filling and taping the boxes. (Tr.110-111). Dallas admitted that she was not working with Petitioner at the time that he was injured so he could have been working at the end of the line unloading boxes at the time this accident occurred. Dallas admitted that if that would occur, his job would have involved unloading 15 to 20 pieces per minute from the conveyor belt down to the pallet. Dallas admitted that the people from Elite Staffing who are monitoring this line are moving pretty quick to keep up with the production. (Tr.112).

On re-direct, Petitioner testified that after hearing the testimony of Dallas, she was incorrect with where this injury had occurred. (Tr.114-115). Petitioner testified that he started the day in the middle area taping boxes. However, he was switched with another person in the afternoon to the end of the line stacking boxes. (Tr.115). Petitioner testified that he had been moved to the end of the line because he could not keep up with the middle of the line as he was too slow. Additionally, Petitioner testified that although Dallas described the activity of moving his feet instead of twisting his body, he did not perform this activity by moving his feet but instead twisted his body in order to keep up with the pace of unloading the boxes onto the pallet. (Tr.115-116).

Dallas was recalled and testified that there was a statement made by Petitioner that he was standing on Line C loading boxes into the tape machine when he had injured his low back.

Dallas testified that the middle of Line C was not the same as the palletizing job. (Tr.120-121). According to the injury report, Petitioner stated that he turned to his left, caught himself by holding a table and sustained injury to his low back. (Tr.121). Dallas believed that when Petitioner discussed a table that he meant the table in the middle of Line C.

Dr. Helen Blake testified on behalf of Petitioner. Blake noted that she is a pain management specialist board certified in both anesthesia and pain management. Dr. Blake testified that Petitioner was referred to her by Dr. Mark Eavenson. (Tr.5-8). (Px.1). Dr. Blake reviewed the prior medical records with Dr. Eavenson and confirmed that Petitioner had had sporadic low back pain that had resolved by December of 2012. (Tr.11).

Dr. Blake testified that when she met with Petitioner, he had advised her that he was lifting a box that weighed approximately one pound when he twisted and began having stabbing pains in his low back. Dr. Blake noted in reviewing the medical records from various providers that it was not the weight that caused problems to the back but it was more the twisting activities that she felt brought about the onset of low back pain. (Tr.13-15). Dr. Blake testified that she was factoring in the twisting episode as being the factor that caused the onset of the symptoms. (Tr.17).

Dr. Blake testified that Petitioner had a positive Faber's test as well as a positive straight leg raising. Dr. Blake testified that it indicated to her that Petitioner had sustained a sacroiliac joint strained with compression on a nerve root. (Tr.19). Dr. Blake reviewed the MRI and confirmed that it showed a disc protrusion that was projecting into the L5 neuroforamen with mild facet hypertrophy and a broad based disc protrusion causing some mild central spinal stenosis at L4-5.

Based upon her examination of Petitioner, Dr. Blake diagnosed him with having a sacroiliac joint dysfunction. She also felt that he had degenerative changes that were aggravated by his work injury. As a result, she recommended and completed an epidural steroid injection. (Tr.25). Dr. Blake testified that by October 17, 2013, Petitioner had excellent relief of his pain from the sacroiliac joint injection but was still continuing to have low back pain. Dr. Blake testified that she felt that the injection had reached its endpoint causing the low back symptoms to return. (Tr.27-28). Dr. Blake testified that while SI joint injections can provide temporary pain relief, it is possible for the symptoms to return necessitating further injections. (Tr.28-29). Dr. Blake noted although Petitioner had significant muscle spasms, he no longer had the SI joint tenderness. As a result, Dr. Blake completed some trigger point injections to break up the muscle spasms and provided a second epidural injection.

By November 7, 2013, Dr. Blake noted that the injections improved Petitioner's pain significantly at first but then the symptoms returned a second time. Dr. Blake testified that the purpose of the injections was to decrease the inflammation to try to return the patient to a pain free state. Dr. Blake noted that following the second injections, Petitioner had stated that the symptoms down his left leg had not returned which showed that the pressure on the nerves had been rectified by way of the injections. (Tr.34-35).

On December 19, 2013, Dr. Blake performed a left L4-5 and L5-S1 facet joint injection. She noted that these injections were diagnostic in nature and were basically in preparation for

those joints. However, Petitioner did not return after that visit. (Tr.38). Dr. Blake testified that without undergoing any further treatment, it would certainly be possible that he would have continuing symptoms in his low back. (Tr.41).

CONCLUSIONS:

Issue C: Did an accident occur that arose out of and in the course of Petitioner's employment by Respondent; the Arbitrator makes the following conclusions:

The Illinois Workers' Compensation Act is a humane law of a remedial nature, and wherever construction is permissible, its language is to be **liberally construed** to effect the purpose of the Act. ***Shell Oil Co., v. Industrial Comm'n***, 2 Ill. 2d 590, 119 N.E.2d 224 (1954), *citing* ***City of West Frankfort v. Industrial Comm'n***, 406 Ill. 452, 94 N.E.2d 413 (1950); ***Lambert v. Industrial Comm'n***, 411 Ill. 593, 104 N.E.2d 783 (1952). "Every injury sustained in the course of the employee's employment, which causes a loss to the employee, should be compensable." ***Id.*** at 596, citing ***Petrazelli v. Propper***, 409 Ill. 365, 99 N.E.2d 140 (1951); ***Lambert v. Industrial Comm'n***, 411 Ill. 593, 104 N.E.2d 783 (1952).

It is axiomatic that the Petitioner bears the burden of establishing, by a preponderance of credible evidence, all of the elements of his claim. ***Illinois Institute of Technology vs. Industrial Comm'n***, 68 Ill. 2d 236 (1977). The requirement that the Petitioner prove by "preponderance of the evidence" all elements of his claim, means that he must present evidence which is more credible and convincing to the mind; and, when viewed as a whole establishes the fact sought to be proved as more probable than not. ***In Re: K.O.***, 336 Ill. App. 3d 98 (2002). It is the duty of the arbitrator to view the evidence in it's entirety and determine, objectively and reasonably, whether witness testimony is credible, that is, "worthy of belief," based on the totality of the evidence. ***Thorson v. Carlson Roofing Company***, 01 LLC. 0251.

In order to obtain compensation under the Act, the Petitioner must show, by the preponderance of the evidence, that he suffered a disabling injury arising out of and in the course of his employment. ***Sisbro, Inc. v. Industrial Comm'n***, 207 Ill.2d 193, 203, 797 N.E.2d 65, 278 Ill.Dec. 70 (2003). However, the Petitioner needs only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury. ***Teska v. Industrial Comm'n***, 266 Ill.App.3d 740, 742 640 N.E.2d 13 (1994).

However, even if the injury arose from Petitioner's pre-existing condition, the Act will not relieve Respondent from liability. The case law is well-settled that a work injury is compensable 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." ***Laclede Steel Co. v. Industrial Comm'n***, 6 Ill 2d 296, 128 N.E. 2d 718 (1955). Further, a work injury is compensable within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of the Petitioner's employment. ***Mathiessen & Hageler Zinc Co. v. Industrial Board***, 284 Ill 378, 120 N.E. 249 (1918). An employer is not relieved of liability under the Illinois Workers' Compensation Act because the injury arose from a pre-existing condition. ***A.C. & S. v.***

gives way under the stress of his usual labor." ***Laclede Steel Co. v. Industrial Comm'n***, 6 Ill 2d 296, 128 N.E. 2d 718 (1955). Further, a work injury is compensable within the meaning of the Act when it is traceable to a definite time, place, and cause and occurs in the course of the Petitioner's employment. ***Mathiessen & Hageler Zinc Co. v. Industrial Board***, 284 Ill 378, 120 N.E. 249 (1918). An employer is not relieved of liability under the Illinois Workers' Compensation Act because the injury arose from a pre-existing condition. ***A.C. & S. v. Industrial Comm'n***, 304 Ill.App.3d 875, 882, 710 N.E.2d 837, 842 (2000). The Respondent takes its employees as it finds them. ***General Refractories v. Industrial Comm'n***, 255 Ill.App.3d 925, 930, 627 N.E.2d 1270, 1274 (1994). The Petitioner needs only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury.

The Petitioner need only show that some act of employment was a causative factor, not the sole or principal cause, of the resulting injury. ***Teska v. Industrial Comm'n***, 266 Ill.App.3d 740, 742, 640 N.E.2d 13 (1994). The claimant must show, inter alia, that some aspect of his employment was a causal factor that resulted in the complained of injury. ***Teska*** at 742. The fact that the employee had a pre-existing condition, even though the same result may not have occurred had the employee been in normal health, does not preclude a finding that the employment was a causative factor. ***County of Cook v. Industrial Comm'n***, 69 Ill.2d 10, 17, 370 N.E.2d 520, 523 (1977). Proof of the state of health of an employee prior to and down to the time of the injury, and the change immediately following the injury and continuing thereafter, is competent as tending to establish that the impaired condition was due to the injury. ***Kress Corp. V. Industrial Commission***, 190 Ill. App. 3d 72, 82 (1989) p. 14. The Arbitrator finds that the workplace injury was a causative factor of Petitioner's current condition of ill-being. Based on the record, the Arbitrator, therefore, finds that the Petitioner established that his present condition of ill-being with regard to his cervical neck and low back is causally related to his accident of August 6, 2012.

In the present case, Petitioner testified credibly that on April 17, 2013, while performing twisting activities at work, he noticed a sharp pain in his low back causing his legs to give out. Petitioner was taken by ambulance to the emergency room due to ongoing problems with his low back.

Respondent offered no eyewitness to contradict Petitioner's history and description of his work accident. In fact, Respondent's witness confirmed that Petitioner's work activities were repetitive in nature and required that he unload 15 to 20 boxes per minute from the conveyor belt to the pallet on the ground. Petitioner's history of accident is confirmed by the medical history at Gateway Regional Medical Center as well as Gateway Regional Occupational Health. In both histories, Petitioner described the repetitive twisting activities as being the causative factor in bringing about his low back symptoms as well as problems going down into his legs.

Petitioner admitted to having prior low back complaints that were musculoskeletal in nature. Medical records regarding this treatment were entered into evidence and confirm that Petitioner had been diagnosed with having musculoskeletal strains in the past. However, review of these medical records failed to show any form of lower extremity symptoms prior to the date of accident.

As a result, Petitioner sustained a work accident that stemmed from his repetitive twisting activities of unloading boxes from the conveyor belt to the ground. Petitioner's credible explanation of a work accident is confirmed by the medical records. Additionally, the repetitive nature of Petitioner's work activities is confirmed by Respondent's own witness.

Issue F: Is Petitioner's current condition of ill-being causally related to the accident; the Arbitrator makes the following conclusions:

As noted above, on April 17, 2013, Petitioner sustained a work injury while twisting and unloading boxes from a conveyor belt to a pallet. At that time, he noted sharp pain in his low back as well as weakness going down his leg. He was initially taken to the emergency room and was thereafter sent to Gateway Regional Occupational Health by the employer. An MRI taken at that time confirmed two protruding discs in his low back. Petitioner was referred to Dr. James Coyle for an evaluation at the request of the employer. Thereafter, Dr. Coyle had recommended that Petitioner undergo injections as well as a referral for pain management. This medical treatment was denied based upon Dr. Coyle's conclusion that there was no work accident.

However, Dr. Coyle's conclusions were based upon an incorrect history of injury. Dr. Coyle focused on the weight of the box in concluding that the work activities were not enough to cause Petitioner's symptoms. Petitioner testified that it was not the weight of the box but the repetitive twisting 15-20 times per minute in moving the boxes from the conveyor belt to the pallet that led to the work injury. Petitioner's testimony on this issue is consistent with the medical records. Respondent initially agreed with Petitioner's testimony and had provided medical treatment and lost time benefits.

After being denied treatment with Dr. Coyle, Petitioner underwent treatment consistent with Dr. Coyle's recommendations of injections and pain management. Petitioner testified that his symptoms never remitted following the work injury but that the medical care assisted in reducing the level of symptoms in the low back and removed the symptoms going down the left leg. Petitioner testified that he had no subsequent intervening event.

Based upon the foregoing, the Arbitrator finds that the work related accident of April 17, 2013, either caused or aggravated the two protruding discs in Petitioner's low back which necessitated the medical treatment and injections identified in the medical records.

Issue J: Were the medical services provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services? The Arbitrator finds as follows:

Petitioner introduced Petitioner's Exhibit 9, a package relating to medical bills as well as a medical bill summary. Petitioner testified that the bills shown in the exhibit were incurred as a result of the work injury. Respondent had paid a portion of the medical bills but denied liability following the evaluation with its doctor, Dr. James Coyle. The charges are as follows:

Optum	$1,911.00

Granite City ER Physicians	$1,322.00
Multicare Specialists	$6,370.00
Dr. James Coyle	$375.00
Pain & Rehab Specialists	$8,468.61
Regeneration Orthopedics	$1,358.59
IWP	$2,163.57
CVS Pharmacy	$24.22
The Medicine Shoppe	$89.54
Totals	$20,171.53

The Arbitrator orders Respondent to pay $20,171.53, pursuant to the medical fee schedule. This medical treatment is reasonable, necessary, and related to Petitioner's work injury. Respondent is provided a credit in the amounts paid, totaling $1,911.04. The bills listed above are to be paid pursuant to the medical fee schedule, Section 8.2 of the Act.

IssueK: What temporary total disability benefits are in dispute; The Arbitrator finds as follows:

Petitioner testified that following his work injury, he was placed on light duty restrictions by the emergency room and was not released to return to full duty until September 9, 2013. Petitioner testified that he provided these light duty restrictions to his employer who was unable to accommodate the light duty restrictions.

As a result, the Arbitrator orders Respondent to pay lost time benefits from April 17, 2013 through September 9, 2013, totaling 20-6/7 weeks at $220.00 per week for a total of $4,588.57. Respondent had already paid a portion of this totaling $421.90 and will be given a credit to this amount.

Issue L: What is the nature and extent of the injury? The Arbitrator finds as follows:

Petitioner testified that as a result of the work injury, he continues to have an uncomfortable pain in his low back that he evaluates as 2 out of 10. Petitioner testified that as a result of this work injury, he continues to require ongoing over-the-counter Ibuprofen to help to control his symptoms. Petitioner testified that he has been able to return to work on a full time status driving trucks but notes that he does no loading or unloading of the loads. Petitioner's testimony is consistent with the medical records from Dr. Blake who confirmed ongoing problems in Petitioner's low back and in fact had recommended further medical treatment.

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

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

(b) Also, the Commission shall base its determination on the following factors:
(i) the reported level of impairment as assessed pursuant to the current edition of the AMA "Guides to the Evaluation of Permanent Impairment";
(ii) the occupation of the injured employee;
(iii) the age of the employee at the time of the injury;
(iv) the employee's future earning capacity; and
(v) evidence of disability corroborated by the treating medical records.

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

1. The reported level of impairment under the AMA Guides. With regard to the AMA Impairment Rating, the Arbitrator notes that neither party has submitted an impairment rating under the AMA Guides.

2. The occupation of the injured employee. Petitioner's current occupation is that of an over-the-road truck driver. Petitioner has been in this position since being released full duty following this work accident. Petitioner has continued to work full duty without any restrictions although he notes that he does not have to manipulate any of the loads within his truck.

3. The age of employee at the time of the injury. At the time of his accident, Petitioner was 45 years old. Petitioner has a long work life ahead of him and has no plans to retire or stop working. Petitioner noted that his low back problems may limit his ability to move freight from trucks but he has been able to find employment that does not require the physical manipulation of loading and unloading trucks. Regardless, due to his age, one may reasonably infer that Petitioner will live with the residuals of his injury for a longer time than an older individual and with pain and limitations which affect his ability to fully bend over or load and unload trucks.

4. The employee's future earning capacity. Petitioner testified that he has been able to return to work full duty and has been working without any form of work restrictions. Petitioner testified that he continues to have ongoing low back pain that requires ongoing Ibuprofen but there exists no evidence of a potential diminishment of future earning capacity due to his work injury.

5. Evidence of disability corroborated by the treating medical records. Petitioner testified credibly to ongoing problems with pain and stiffness in his low back. Petitioner noted that the symptoms going down his left leg resolved with the epidural injections and treatment provided by Dr. Blake. However, he continues to have an uncomfortable pain that is a 2 out of 10. The complaints of limitations are corroborated by the medical records of Dr. Eavenson, Dr. Blake, and the MRI which confirms that Petitioner has two levels of protruding discs which cause ongoing low back problems. While Dr. Blake had recommended further medical care, Petitioner was of the belief that he had reached maximum medical improvement.

After considering all of the foregoing, the Arbitrator concludes Petitioner sustained disability to the extent of 4% disability of the man as a whole at the low back or 20 weeks disability under Section 8(d)(1) of the Act.

Issue O: Mileage

Petitioner is awarded mileage for one visit to Dr. James Coyle at 51.2 miles at the statutory rate at the time of the accident (56.5¢) for a total award $28.36. The medical treatment that Petitioner underwent was at the request of Respondent who sent Petitioner to Dr. Coyle for medical treatment. As Respondent sent Petitioner from his home in Illinois to a doctor in St. Louis, Missouri, one may infer that it was reasonable and necessary for Petitioner to travel to St. Louis as Respondent did not opt to choose a local doctor.

Section 8(a) of the Workers' Compensation Act provides as follows:

> "The employer shall provide and pay…for all necessary first aid, medical, and surgical services reasonably requested to cure or relieve from the effects of the accidental injury…the employer shall also pay for treatment, instruction and training necessary for the physical, mental, and vocational rehabilitation of the employee, *including all maintenance costs and expenses thereto.*" 820 ILCS 305/8(a)(*emphasis added*).

The Commission has previously interpreted 8(a) to include reasonable expenses for travel. The Commission has noted "we are of the opinion that the reasonable expense incurred for travel or transportation to obtain such medical treatment is an expense incidental to treatment necessary for the physical rehabilitation of the employee." ***Ron Smith v. Roy Stinde and Daughters Excavating***, 5 IWCC 208 (March 8, 2005). The Commission noted that these are expenses that petitioner would not have incurred had he not sustained a work injury. ***Id.*** 1—2; *See also*, ***Osborn v. Myerscorff Payroll Service d/b/a Stadium Grill***, 14 IWCC 1108 (Dec. 19, 2014). The Commission decisions are consistent with the Appellate Court who upheld an award of mileage expenses from an injured worker who traveled approximately 100 miles to see his physician who had moved. ***General Tire and Rubber Co. v. Industrial Comm'n***, 221 Ill.App. 3rd 641, 582 N.E.2d. 744, 164 Ill.Dec. 181 (1991). The Appellate Court affirmed the Commission's decision that the medical care was "reasonably necessary." ***General Tire*** at 750-751.

In the present case, Petitioner was not provided an option of seeking care locally but instead was advised by Respondent that his medical care was being directed to a doctor in St. Louis. Petitioner testified that he would have sought local medical care and not incurred the expenses associated with having to travel each way to St. Louis. However, since Respondent required that Petitioner seek medical care in St. Louis, it certainly makes the mileage a "reasonable expense" incidental to treatment necessary for the physical rehabilitation of the employee. As such, Petitioner is awarded mileage reimbursement of $28.36.

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

Elaena Garcia, as Petitioner on behalf of herself and on behalf of Minor Allen J L Meye Jr., son of Allen Meye Deceased,
Petitioner,

vs. NO: 13 WC 27398

Marion Clarida d/b/a Northwest Design and Country Mutual Insurance Company,
Respondent.

17IWCC0528

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, casual connection, medical expenses, average weekly wage, and penalties and attorney's 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 underlying facts of this claim were well laid out in the Arbitrator's Decision, which is incorporated herein, and the Arbitrator's findings of fact are adopted. The Commission further affirms the Arbitrator's determination as to causal connection between the original accident and the injuries sustained, as well as the duration of temporary total disability benefits, the assessment of the nature and extent of the injury, and the denial of penalties and fees.

17IWCC0528

With regards to the average weekly wage, the Arbitrator calculated the claimant's wages to be $222.75 given his highly irregular schedule. The Commission observes, as did the Arbitrator, that the claimant worked part-time with sporadic and atypical work weeks, with a total of 94.5 hours worked over 16 days between October 22, 2007 and November 26, 2007. The Commission reviews this evidence in accord with the cases of *Cook v. Industrial Commission*, 231 Ill.App.3d 729, and *Rickets v. Industrial Commission*, 251 Ill.App.3d 908 (1993), and calculates the claimant's proper average weekly wage to be $236.25, based on the total wages of $945.00 divided by the four weeks during which the claimant worked in whole or in part.

With regard to the number of dependents, the Arbitrator found that the claimant had fathered Allen Maye, Jr., but found no dependency in the sense of financial contribution and made a finding of zero dependents. The Commission notes that, in addition to the proof of parentage, the respondent had stipulated to the claimant's having one dependent. As such, the Commission modifies the Arbitrator's findings to show the claimant was single with one dependent. Given the above findings as to average weekly wage, the TTD and PPD rate are accordingly set at $230.00 per week (the statutory minimum).

With regards to credit for disability benefits paid, the Commission notes and corrects what originally appears to be a discrepancy in the Arbitrator's decision. In the "Findings" section of the cover page, the Arbitrator noted credit for $12,148.57 in TTD, but in the "Conclusion of Law" section in the text of the award, the Arbitrator noted credit available for payments made in the amount of $37,120.00. The $37,120.00 is also the figure referenced on the stipulation sheet and, as the Arbitrator noted in the body of his decision, does have independent factual support. The apparent basis for the discrepancy is that the Arbitrator found the respondent liable for 108 & 4/7 weeks of TTD, a total liability of $24,971.43. As such, there has been an overpayment of disability benefits of $12,148.57 which would be credited against any further permanent disability award. As such, the Commission accordingly amends the $12,148.57 figure, which appears to be the overpayment, to the correct $37,120.00 figure, but will note the overpayment for credit against other benefits awarded.

Lastly, with regard to payments and dependency, the Arbitrator found the respondent liable for certain medical benefits, as well as 108 & 4/7 weeks of TTD, a total liability of $24,971.43. As such, there has been an overpayment of disability benefits of $12,148.57 which would be credited against any further permanent disability award. The Arbitrator's finding of 30% permanent partial disability to the right foot, with which the Commission concurs and adopts, represents a liability of 50.1 weeks' worth of disability benefits, or $11,523.00. As such, given the amount of the credit, there is no present amount remaining due and owing for disability. If any remaining benefits are shown to have accrued beyond the remaining credit of $625.57, then in accordance with the findings of parentage and dependency noted above and in light of the holding in *Salvatore DiVittorio v. Industrial Commission*, 299 Ill.App.3d 662 (1st Dist. 1998), those benefits would be paid to Allen Maye, Jr., as the dependent of the claimant within the context of Section 8(e)19.

Beyond the above-noted modifications, the Arbitrator's decision is otherwise hereby affirmed and adopted.

17IWCC0528

IT IS THEREFORE ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $230.00 per week for a period of 108-4/7 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, as delineated in the attached decision, the Respondent shall pay the reasonable and necessary medical charges provided to the claimant through December 16, 2009, subject to the limits of Sections 8(a) and 8.2 of the Act.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $230.00 per week for a period of 50.1 weeks, as provided in §8(e) of the Act, as the injuries sustained caused the loss of use of the right foot to the extent of 30%.

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 $24,500.00. 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 25 2017

Joshua D. Luskin

o-07-26-17
jdl/ac
68

Charles J. DeVriendt

L. Elizabeth Coppoletti

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

GARCIA, ELAENA AS PETITIONER ON BEHALF OF HERSELF AND ON BEHALF OF MINOR ALLEN J L MEYE JR SON OF ALLEN MAYES DECEASED
Employee/Petitioner

Case# **13WC027398**

17IWCC0528

MARION CLARIDA D/B/A NORTHWEST DESIGN AND COUNTRY MUTUAL
Employer/Respondent

On 1/6/2016, 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 0.50% shall accrue from the date listed above to the day before the date of payment; however, if an employee's appeal results in either no change or a decrease in this award, interest shall not accrue.

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0075 POWER & CRONIN LTD
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OAK BROOK, 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)
☒ None of the above

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Elaena Garcia, as petitioner on behalf of herself and on behalf of minor, Allen J. L. Maye, Jr., son of Allen Maye, deceased
Employee/Petitioner

Case # 13 WC 27398

v.

Marion Clarida d/b/a Northwest Design and Country Mutual Insurance Company
Employer/Respondent

17IWCC0528

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable **Steven Fruth** Arbitrator of the Commission, in the city of **Chicago**, on **March 23, 2015**. After reviewing all of the evidence presented, the Arbitrator hereby makes findings on the disputed issues checked below, and attaches those findings to this document.

DISPUTED ISSUES

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

17IWCC0528

FINDINGS

On **November 26, 2007** Respondent ***was*** operating under and subject to the provisions of the Act.

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

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

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

The employee's condition of ill-being **regarding the right ankle** ***is*** causally related to the accident, but that the employee's condition of ill-being **regarding the low back** ***is not*** causally related to the accident.

In the year preceding the injury, the employee earned **$11,583.00**; the average weekly wage was $222.75.

On the date of accident, the employee was **30** years of age, ***single*** with **0** dependents.

The employee ***has*** received all reasonable and necessary medical services.

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

Respondent shall be given a credit of **$12,148.57** 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

Respondent shall pay all reasonable and necessary medical service charges for healthcare provided to decedent Allen J. L. Maye by Dr. Bruce Montella and Midwest Sports Medicine and Orthopedic Surgery through December 16, 2009, subject to the fee schedule of the Act

The common law Estate of Allen J. L. Maye, deceased, shall be awarded **108 & 4/7** weeks of total temporary disability benefits, with due credit to Respondent for any overpayment.

The common law Estate of Allen J. L. Maye, deceased, shall be awarded **30%** of a foot, or **50.1** weeks, for injuries sustained by Allen J. L. Maye, deceased, on November 26, 2007

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 6, 2016
Date

JAN 6 - 2016

Elaena Garcia as Petitioner on behalf of herself and on behalf of minor, Allen J. L. Maye, Jr., son of Allen Maye, deceased

v.
Marion Clarida d/b/a Northwest Design and County Mutual Insurance Co.
No. 13 WC 08866

INTRODUCTION

This matter proceeded to hearing on March 23, 2015 before Arbitrator Steven Fruth. The disputed issues were: ***F:*** Is Petitioner's current condition of ill-being causally related to the accident?; ***G:*** What were Petitioner's earnings?; ***J:*** Were the medical services that were provided to Petitioner reasonable and necessary? Has Respondent paid all appropriate charges for all reasonable and necessary medical services?; ***K:*** What temporary benefits are in dispute? TTD; ***L:*** What is the nature and extent of the injury?; and ***M:*** Should penalties be imposed upon Respondent?

Elaena Garcia testified at trial. The parties offered various exhibits which were admitted without objection, including the evidence depositions of Drs. Bruce Montella and Theodore Suchy. Petitioner's objections to Respondent's Exhibits #2 (Dr. Suchy August 24, 2009 report of follow-up §12 exam) and #3 (Dr. Suchy January 7, 2013 report of follow-up §12 exam) were well taken and the exhibits were refused admission. Petitioner's objections to Exhibits #2 and #3 of Dr. Suchy's deposition (RX #1) were sustained and the Arbitrator disregarded those deposition exhibits. Petitioner objected to Respondent's Exhibit # 16. The objection to RX #16 was over-ruled and the exhibit was admitted.

FINDINGS OF FACT

Elaena Garcia testified that the deceased Allen Maye was the natural father of her son Allen Maye, Jr. She testified that the decedent provided care for herself and Allen Jr. He would take his son out to eat and to the movies. Ms. Garcia testified that the decedent gave her cash and clothing and paid some bills. The decedent also helped with household chores. After he was injured the decedent came around less often and would then only sit and watch television. Because of his injury Mr. Maye was not able to pay for expenses or engage in other activities as he had been before the injury.

Petitioner's Exhibit #12, a noncertified photocopy of a Certificate of Live Birth of Allen Ja'Marco Lamont Maye, Jr., was admitted in evidence. Decedent Allen Ja'Marco Lamont Maye was listed as father. Petitioner's Exhibit #14, a photocopy of Voluntary Acknowledgement of Paternity, was also admitted in evidence. PX #14 is neither certified nor notarized. The only readable signature on PX #14 is that of witness Janet Brooks.

At the time of his November 26, 2007 work injury Allen Maye was employed by Marion Clarida d/b/a Northwest Design. On November 26, 2007 Mr. Maye fell from a ladder at work. Mr. Maye suffered a traumatic fracture to his right ankle. Mr. Maye was transported to St. Alexius Medical Center (PX #1 & RX #4).

In the Emergency Department of St. Alexius Mr. Maye gave a history of seizure disorder which was poorly controlled by Dilantin, with seizures every 2 months or so. His Dilantin level was noted as subtherapeutic. He reported that while on a ladder he experienced an aura which indicated an onset of a seizure. He fell as he was descending the ladder. Mr. Maye also gave a history of smoking but denied use of recreational drugs. X-rays confirmed an oblique and displaced fracture of the distal tibia, an avulsion fracture of the distal fibula with displacement, and fractures of metatarsals.

Orthopedic surgeon Dr. Bruce Montella performed an open reduction with internal fixation on November 27. Mr. Maye was discharged from St. Alexius on November 28.

Dr. Montella testified at evidence deposition on April 30, 2009 (PX #11) that he performed emergency surgery, in which he "lined up" Mr. Maye's ankle bones and installed plates and screws to hold Mr. Maye's ankle after the injury he sustained when he fell from a ladder.

After his ankle surgery Mr. Maye continued with Dr. Montella, at Midwest Sports Medicine and Orthopedic Surgery (PX #2 & RX #5), beginning December 10, 2007. In his initial intake form at Midwest Sports Medicine Mr. Maye reported pain in his right ankle, foot and toes that radiated through his entire right leg. Mr. Maye reported his history of seizures but the form did not ask for a history of illicit or recreational drug use. At that time Dr. Montella restricted Mr. Maye from any work. Dr. Montella applied a cast and continued Mr. Maye's use of crutches.

The decedent continued treating with Dr. Montella throughout 2007 and 2008. Dr. Montella continued to restrict Mr. Maye from all work. He also recommended physical therapy and prescribed orthotics. Mr. Maye's complaints and clinical presentation throughout 2008 was essentially the same: continued pain and limitation requiring physical therapy and pain medication as well as remaining off work. Mr. Maye's continued stiffness and pain and work restrictions were noted October 2, 2008. At that time Dr. Montella recommended an MRI if symptoms did not improve to determine if additional surgery to remove any loose bodies was warranted.

On October 6, 2008 the decedent underwent a valid functional capacity evaluation (FCE). Mr. Maye was found to be able to work in the medium DOT category.

On consultation October 27, 2008 Dr. Montella noted that Mr. Maye continued complaints of severe ankle pain. Dr. Montella also noted that Mr. Maye now complained of back pain with radiating leg pain along with numbness and tingling into his lateral thigh. Dr. Montella recommended a lumbar MRI. Dr. Montella diagnosed chronic pain consistent with post-traumatic arthrosis in his ankle.

On December 12, 2008 Dr. Montella noted Mr. Maye continued to have difficulties with his ankle and that he is now having back and radiating leg pain as a result of his altered gait due to the ankle injury. Dr. Montella continued to recommend the lumbar MRI and continued physical therapy and medication.

The decedent continued to follow-up with Dr. Montella in 2009. On January 14 Mr. Maye reported that he had been involved in a motor vehicle accident. He then had neck pain and a worsening of his back pain. Dr. Montella noted that the ankle injury had altered Mr. Maye's gait which led to the onset of the back problems which were work related. Dr. Montella continued to restrict Mr. Maye from work of any kind and ordered MRIs of both the neck and back. He continued to recommend physical therapy.

On February 18 it was noted that Mr. Maye continued to experience significant difficulties with his ongoing ankle pain since his work injury. Dr. Montella further noted that Mr. Maye's back symptoms were consistent with a lumbar disc herniation and radiculitis and a chondral injury to the ankle. Dr. Montella recommended a series of epidural injections for the back injury. He continued to restrict Mr. Maye from any work activity.

Dr. Montella's records of March 11, 2009 noted that Mr. Maye's back and ankle injury, both of which were directly related to his work injury continued to cause him a lot of problems. Mr. Maye completed a Patient Assessment form in which he gave a health and family history. Mr. Maye denied use of recreational drugs in the Patient Assessment. On April 23, June 4, and July 2, 2009 Dr. Montella noted that Mr. Maye's difficulties to be ongoing and continue to be severe and debilitating. Dr. Montella noted discogenic back pain and advised continued physical therapy and narcotic pain medication.

The decedent submitted to a Vocational Assessment on May 29, 2009 (PX #10). The decedent gave a history smoking 1 pack per day and occasional alcohol use. It was noted that the decedent's 4 year old son resided with him ½ time. He completed the 11th grade in Alabama but never completed a GED. The decedent also gave a history of incarceration for felony cocaine possession until March 2001 and was at the time of the assessment facing felony charges for possession of cocaine with intent to deliver. The decedent also gave a history of seizure disorder since age 15. The decedent also reported a history mental health intervention for psychological problems that arose after his injury. The decedent's work history was heavy in nature.

The Vocational Assessment noted that the decedent was employable but his employability was limited due to his criminal history and underlying health problems.

On July 30 Dr. Montella noted Mr. Maye's continuing ankle pain was related to retained hardware. Mr. Maye wished to have the hardware removed. Dr. Montella recommended hardware removal on October 1, 2009 at Instant Care, LLC (PX #4). On the pre-operative patient history form Mr. Maye noted that he smoked ½ a pack-a-day and denied recreational drug use. Dr. Montella removed 9 screws and an 8-hole plate on out-patient basis on December 1, 2009. Prior to the hardware removal Mr. Maye was evaluated by neurologist Dr. Daniel Cacioppo pre-operative assessment on October 27. Dr. Cacioppo noted Mr. Maye's history of seizures and alcohol consumption which triggered seizures in the past. Mr. Maye denied current drug use. Post-operative visits with Dr. Montella on December 16, 2009 and on January 18, 2010 related to assessment

of the ankle as well as Mr. Maye's low back complaints. The January visit seemed more focused on the back than on the ankle.

Mr. Maye received physical therapy at The Centers for Physical Therapy (PX #3) from February 19 through June 3, 2008. The therapy was pursuant to Dr. Montella's orders. Therapy was restricted to Mr. Maye's right ankle. There were no notes of complaints of back pain over the course of the therapy. There were no notes of physical therapy for the back.

The decedent submitted to a Vocational Assessment on May 29, 2009 (PX #10). The decedent gave a history smoking 1 pack per day and occasional alcohol use. It was noted that the decedent's 4 year old son resided with him ½ time. He completed the 11th grade in Alabama but never completed a GED. The decedent also gave a history of incarceration for felony cocaine possession until March 2001 and was at the time of the assessment facing felony charges for possession of cocaine with intent to deliver. The decedent also gave a history of seizure disorder since age 15. The decedent also reported a history mental health intervention for psychological problems that arose after his injury. The decedent's work history was heavy in nature.

The Vocational Assessment noted that the decedent was employable but his employability was limited due to his criminal history

In his evidence deposition on April 30, 2009 (PX #8) Dr. Montella opined that Mr. Maye's back pain was due to the work-related injury. He further testified that when a person suffers a severe injury to one part of his body it is common to be distracted from a less serious injury. He went on to testify that a lower extremity injury alters gait, which puts stress on the back, which leads to the onset of back pain. Dr. Montella testified that he recommended an MRI of Mr. Maye's lumbar spine. He diagnosed a lumbar disc herniation.

Dr. Montella further testified that Mr. Maye's prognosis for recovery from his work injury was guarded. He went on to testify that all of Mr. Maye's physical exam findings were consistent with his diagnosis and treatment plan, although he acknowledged that he did not document clinical examination findings. Dr. Montella also testified that Mr. Maye's continued pain in his right ankle has limited his recovery. He further testified that even after Mr. Maye's FCE he did not feel Mr. Maye could not perform any work due to the fact Mr. Maye continued to require narcotic pain medication for his ankle pain.

The medical records of the decedent from the Illinois Department of Corrections were admitted as Respondent's Exhibit #19. Mr. Maye received mental health care throughout his incarceration from January 2010 and August 2012. During that time his complaints about his right ankle were also documented. There are no documented complaints of back pain within the IDOC records.

The decedent saw Dr. Montella on February 1, 2013 (PX #2). Mr. Maye complained of residual right ankle pain and limitations. Dr. Montella noted that Mr.

Maye had reached maximum medical improvement and that he sustained a permanent disability, which will require continued medication and therapy.

Dr. Theodore Suchy examined Mr. Maye at Respondent's request pursuant to §12 of the Act on September 2, 2008 (RX #14).

Dr. Suchy gave his evidence deposition on June 1, 2009 (RX #1). He is a board certified orthopedic surgeon. Dr. Suchy testified regarding his §12 exam and records review. At the examination on September 2, 2008 Mr. Maye gave Dr. Suchy a history of his right ankle and foot injury. At that time Mr. Maye denied any neck or back injuries. He complained only of pain and swelling in his right ankle. Dr. Suchy specifically asked about neck or back complaints. Dr. Suchy noted an exaggerated limp and magnified subjective complaints. He found a full range of motion in the decedent's right ankle. X-rays indicated a fully healed fracture.

Dr. Suchy testified Mr. Maye sustained a subluxation fracture of his right ankle on November 26, 2007. Mr. Maye underwent appropriate surgical intervention and was at MMI when examined by Dr. Suchy on September 2, 2008. Dr. Suchy opined that Mr. Maye was able to perform his normal work activities. He recommended a functional capacity evaluation.

Dr. Suchy's reports dated September 2, 2008 and December 31, 2008 were attached to RX #1 as Exhibit #2 and Exhibit #3. Petitioner objected to Respondent's offer to admit in evidence Exhibits # 2 and 3. Petitioner argued that the exhibits, which were narrative reports to Respondent's insurer, were created for the purposes of litigation and were therefore inadmissible hearsay. Petitioner's objections were well-taken and are sustained. The Arbitrator notes that Exhibits # 2 and #3 to RX #1 are identical to RX #14 and Rx #15, which were admitted in evidence.

On December 31, 2008 Dr. Suchy reviewed the FCE of October 6, 2008 (RX #15). Dr. Suchy felt that the FCE was valid. He opined again the there was no causal relation of the decedent's back complaints and the workplace accident. Dr. Suchy opined that the decedent was then at MMI and capable of medium duty work.

Dr. Suchy reviewed additional medical records from Dr. Montella. Dr. Suchy noted the decedent's first subjective complaints of back pain were in October 2008. Dr. Suchy testified that there was no causal relationship between the injury of November 26, 2007 and the development of any kind of pathology in Mr. Maye's lumbar spine.

Respondent's Exhibit #2, Dr. Suchy's August 24, 2009 report of a subsequent §12 exam of that date was refused on grounds of hearsay. Respondent's Exhibit #3, Dr. Suchy's January 7, 2013 report of another subsequent §12 exam was also refused on grounds of hearsay.

Respondent served notices for §12 medical examinations of Mr. Maye on August 4, 2008 (RX #7), September 2, 2008 (RX #8), August 24, 2009 (RX #9), June 3, 2010 (RX # 10), October 17, 2011 (RX #11), and January 7, 2013. Mr. Maye appeared and was examined on September 2, 2008, August 24, 2009, and January 7, 2013.

The decedent Allen L. Maye died of causes unrelated to his claimed workplace injuries on February 21, 2014 (PX #11).

CONCLUSIONS OF LAW

Dependency

The Arbitrator finds that Petitioner Elaena Garcia failed to prove that the decedent Allen Maye provided 50% or more of financial support for her or for Allen Maye, Jr. Ms. Garcia testified only in vague terms about the financial support purportedly provided by the decedent. She offered no evidence of dollar amounts purportedly provided by the decedent. She offered no evidence of the total amount of living expenses for herself or her son. Absent such evidence the Arbitrator is unable to make a calculation of whether the decedent provided 50% or more support.

Further, the Arbitrator did not find Ms. Garcia to be a credible witness. She testified to a degree of attention the decedent gave to his son that, given the decedent's criminal lifestyle, drug and alcohol abuse, and mental illness, was not believable.

Petitioner's Exhibits #12 and #14 do not prove that Allen Maye, Jr. is the child of the deceased Allen Maye. The Arbitrator notes that a Birth Certificate, absent the parents being married, is not dispositive proof of parentage. A Voluntary Acknowledgement of Paternity may be dispositive proof of parentage if it can be proven that the purported parent did execute the Acknowledgement. There was no evidence that the decedent in fact signed the Acknowledgement. The signatures on the Acknowledgement cannot be read. The document is neither certified nor notarized. Therefore, the Arbitrator finds that Petitioner's Exhibits #12 and #14 do not prove that Allen Maye, Jr. is the child of the deceased Allen Maye.

Nonetheless, Petitioner Elaena Garcia gave unrebutted testimony that the decedent was the father of Allen Maye, Jr. Despite her questionable credibility discussed above the Arbitrator finds Ms. Garcia's testimony regarding parentage of Allen Jr. to be credible. Even so, Petitioner failed to prove that the decedent had provided support to any degree for Allen L. Maye, Jr.

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

It was not disputed that the decedent sustained a compensable injury to his right ankle that was causally related to his workplace accident on November 26, 2007.

The Arbitrator finds that Petitioner failed to prove that the decedent's claimed condition of ill-being in his low back was causally related to the work accident of November 26, 2007.

The decedent sustained a serious ankle fracture when he fell from a ladder at work on November 26, 2007. That injury required emergency open reduction with

internal fixation by Dr. Bruce Montella. Decedent followed under Dr. Montella's care throughout 2007 and into 2008. Dr. Montella first documented decedent's low back complaints on October 27, 2008, some 11 months after the workplace accident. Dr. Montella testified at his deposition that in his opinion the low back complaints were related to the original injury.

The Arbitrator does not find Dr. Montella's causation opinion about the low back to be persuasive. Dr. Montella opined that the effects of the original ankle fracture caused an alteration in body mechanics which caused the back problem. The Arbitrator does not find this opinion persuasive in light of the extensive passage of time between the accident and the first documented back complaints. Further, at the initial §12 exam by Dr. Suchy on September 2, 2008 Mr. Maye did not complain of back pain. Also, Mr. Maye's medical records from the Illinois Department of Corrections (IDOC) are silent as to complaints of back pain.

In addition, any expert's opinion is only as good as the reliability of the facts on which the opinion is based. Dr. Montella's causation opinion regarding the back is necessarily based on the reliability of the decedent as a historian. The decedent was clearly not a reliable or accurate historian. He had a poorly controlled seizure disorder that he did not disclose to Dr. Suchy at the §12 exam. Decedent consistently reported to treating healthcare providers that he did not use recreational drugs despite 2 felony drug convictions and admission to IDOC healthcare providers of his history of illicit drug use. Mr. Maye reported at one time that his psychological problems developed only after he was injured at work. His IDOC records document his history of severe psychological issues, including a meaningful suicide attempt, beginning in his teens.

The Arbitrator also notes that the treating records from St. Alexius Medical Center where the decedent was first taken on the date of accident (PX #1 & RX #4). The decedent had no complaints of back pain to his initial treating medical providers at St. Alexius Medical Center. He was treated only for a right ankle injury.

The Arbitrator finds, in light of all the evidence, Petitioner failed to prove that the decedent's claim of low back injury was causally connected to the accident of November 26, 2007.

G: <u>What were Petitioner's earnings?</u>

The Arbitrator finds Allen Maye's average weekly wage was $222.75.

The Arbitrator bases this decision on Decedent's wage statement (RX #6). There was no evidence of 52 week earnings. Evidence showed that Mr. Maye worked four weeks in 2007 prior to the accident. During the week of October 22, 2007, he worked 31 hours and earned $310.00. In the week of November 5, 2007, he worked 26.5 hours and earned $265.00. In the week of November 12, 2007, he worked 31 hours and earned $310.00. In the week of November 19, 2007, the final week of employment, he worked 6 hours and earned $60.00. Mr. Maye earned $10.00/hour and worked no

more than 31 hours in any one week.

Based on the averages of disclosed earnings in 2007 the Arbitrator finds the average weekly wage was $222.75. This is adjusted to the minimum applicable TTD rate of $230.00.

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 Respondent has paid or shall pay all reasonable and necessary medical services up to and including December 1, 2009. The Arbitrator previously noted the lack of credibility in Dr. Montella causation opinion regarding the decedent's claimed back injury. Even so, the Arbitrator does defer to Dr. Montella in his care and treatment of Mr. Maye's ankle fracture. Dr. Montella kept Mr. Maye off work in 2007, 2008, and 2009, clearly not believing Mr. Maye had achieved MMI.

The Arbitrator does note Dr. Suchy's opinion that Mr. Maye had reached MMI by the time of the September 2, 2008. This opinion is based on only one examination versus the course of clinical care rendered by Dr. Montella. The clinical record clearly shows that the decedent was symptomatic throughout 2008 and 2009. Mr. Maye's condition was serious enough to warrant follow up surgery to remove fixation hardware on December 1, 2009.

The Arbitrator notes that Dr. Montella provided care for the decedent's back complaints in 2008 and 2009 coincidental to following the ankle injury. The Arbitrator is unable to apportion the degree of services related to the back complaints and what was related to the ankle injury. Respondent's only rebuttal to the reasonableness and necessity of medical care was Dr. Suchy's MMI opinion. The Arbitrator has previously determined that Mr. Maye had not achieved MMI by the time he was incarcerated.

Therefore, in deference to the apparent opinion of Dr. Montella that the decedent required ongoing medical care for his ankle injury through and including December 16, 2009, the Arbitrator finds that Respondent shall pay for all medical services provided by Dr. Montella at Midwest Sports Medicine & Orthopaedic Surgical Specialists, excluding care solely related to assessment or treatment for the claimed back injury. Respondent shall also pay for reasonable and necessary physical therapy for Mr. Maye's ankle injury. Further, Respondent shall also pay for all reasonable and necessary medical services relating to evaluations for the decedent's suitability for the surgical removal of fixation hardware.

K: What temporary benefits are in dispute? TTD

The Arbitrator finds Respondent has paid 128 weeks of temporary total disability benefits at the temporary total disability rate of $290.00/week, for a total of $37,120.00 (RX #17).

Dr. Suchy opined that Petitioner had reached MMI by the time of his §12 exam on September 2, 2008. On the other hand, Dr. Montella opined that Petitioner reached MMI as of February 1, 2013. Nonetheless, Petitioner presented no evidence of why the decedent did not appear for his first scheduled §12 exam on August 4, 2008. Pursuant to §12 of the Act the decedent was not entitled to TTD until he complied with Respondent's request for §12 exam. The decedent did appear for his §12 exam on September 2, 2008. The Arbitrator takes note that Mr. Maye could not appear for the scheduled §12 exams on June 3, 2010 and October 17, 2011 due to his incarceration.

The Arbitrator notes the decedent was sentenced to prison in 2009 upon conviction of possession of a controlled substance with intent to deliver (RX #16). The decedent had been arrested on August 1, 2009 but the date of his conviction is uncertain. Mr. Maye began his incarceration on January 26, 2010. Incarceration removes one from the workforce. Mr. Maye removed himself from the workforce upon his conviction of a crime of specific intent. Regardless, even if the decedent had cooperated with §12 examinations, he was not entitled to TTD after January 25, 2010.

There was no evidence presented that indicate the decedent made any efforts to return to the workforce after his release from prison.

Therefore, the Arbitrator concludes that the decedent was entitled to TTD benefits from November 27, 2007 through August 4, 2008 and from September 2, 2008 through January 25, 2010, or a total 108 & 4/7 weeks. Petitioner has not met her burden of proving the decedent was entitled to any additional TTD benefits.

Respondent is entitled to a credit for any overpayment of TTD benefits.

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

The Arbitrator finds the decedent sustained a partial permanent disability of 30% of the right foot. The Arbitrator bases this decision on the decedent's medical records, the unreliability of the decedent as an accurate historian, and the opinions of Respondent's retained expert, Dr. Suchy.

The decedent suffered a compensable right ankle fracture on November 26, 2007, which required an open reduction with internal fixation. Mr. Maye underwent post-operative conservative care. Due to continuing symptomology the decedent later underwent removal of fixation hardware from his ankle. He continued to be symptomatic after hardware removal, even during his incarceration. The decedent was eventually discharged from treatment by Dr. Montella on February 1, 2013.

M: Should penalties or fees be imposed upon Respondent?

The Arbitrator finds Petitioner did not meet her burden of proving that penalties or fees pursuant to §16 or §19(k) on §19(l) should be imposed upon Respondent.

Although the Arbitrator did not adopt the opinion of Respondent's retained expert, Dr. Suchy, regarding Mr. Maye's attaining MMI, the Arbitrator finds that termination of benefits by Respondent was not frivolous or vexatious. In light of all facts, Respondent acted reasonably and in good faith.

The Arbitrator declines to award penalties or fees in this claim.

Award

Allen L. Maye's death was unrelated to the injury he sustained in the workplace on November 26, 2007. Therefore, §8(e)19 of the Act governs. There was no evidence that a widow survived the decedent. §8(e)19 does provide for the amount payable for a compensable award be made to surviving dependents. Here, Petitioner did prove that Allen Maye, Jr. was the child of the deceased Allen Maye but did not prove, as noted above, that the decedent provided support for Allen Maye, Jr. Thus, Petitioner failed to prove that Allen Maye, Jr. was a dependent of the deceased Allen Maye.

Therefore, any award in accord with the Arbitrator's findings and conclusion stated above shall be to the common law Estate of Allen Ja'Marco Lamont Maye, deceased.

Steven J. Fruth, Arbitrator

January 6, 2016
Date

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Mohammed I. Qureshi,

Petitioner,

vs. NO: 14 WC 10748

17IWCC0529

Flash Cab,

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 December 22, 2015, is hereby affirmed and adopted.

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

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

17IWCC0529

Bond for removal of this cause to the Circuit Court by Respondent is hereby fixed at the sum of $9,900.00. 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 2 9 2017
TJT:yl
o 8/22/17
51

Thomas J. Tyrrell

Michael J. Brennan

Kevin W. Lamborn

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION
CORRECTED

QIRESHI, MOHAMMED I
Employee/Petitioner

Case# **14WC010748**

FLASH CAB
Employer/Respondent

17IWCC0529

On 12/22/2015, an arbitration decision on this case was filed with the Illinois Workers' Compensation Commission in Chicago, a copy of which is enclosed.

If the Commission reviews this award, interest of 0.55% 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:

1515 DWORKIN & MACIARIELLO
THOMAS GAYLE
134 N LASALLE ST SUITE 1515
CHICAGO, IL 60602

4751 DEBORAH L SCHAEFFER
PO BOX 865
ELMHURST, IL 60126

17IWCC0529

☐	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

MOHAMMED I. QURESHI
Employee/Petitioner

Case #14 WC 10748

v.

FLASH CAB
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 November 17, 2015. After reviewing all of the evidence presented, the arbitrator hereby makes findings on the disputed issues, and attaches those findings to this document.

ISSUES:

A. ☐ Was the respondent operating under and subject to the Illinois Workers' Compensation or Occupational Diseases Act?

B. ☐ Was there an employee-employer relationship?

C. ☒ Did an accident occur that arose out of and in the course of the petitioner's employment by the respondent?

D. ☐ What was the date of the accident?

E. ☐ Was timely notice of the accident given to the respondent?

F. ☒ Is the petitioner's present condition of ill-being causally related to the injury?

G. ☐ What were the petitioner's earnings?

H. ☐ What was the petitioner's age at the time of the accident?

I. ☐ What was the petitioner's marital status at the time of the accident?

J. ☒ Were the medical services that were provided to petitioner reasonable and necessary?

K. ☒ What temporary benefits are due: ☐ TPD ☐ Maintenance ☒ TTD?

L. ☒ What is the nature and extent of injury?

M. ☐ Should penalties or fees be imposed upon the respondent?

N. ☐ Is the respondent due any credit?

O. ☐ Prospective medical care?

FINDINGS

- On February 13, 2014, the respondent was operating under and subject to the provisions of the Act.
- On this date, a lessor-lessee 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 $16,588.00; the average weekly wage was $319.00.
- At the time of injury, the petitioner was 47 years of age, married with two children under 18.

ORDER:

- The respondent shall pay the petitioner temporary total disability benefits of $319.00/week for 10-4/7 weeks, from February 15, 2014, through April 29, 2014, which is the period of temporary total disability for which compensation is payable.
- The respondent shall pay the petitioner the sum of $319.00/week for a further period of 20 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 4% loss of use of the man as a whole for his low back strain and left inguinal hernia.
- The respondent shall pay the petitioner compensation that has accrued from February 13, 2014, through November 17, 2015, and shall pay the remainder of the award, if any, in weekly payments.
- The medical care rendered the petitioner for his lumbar spine and left inguinal hernia was reasonable and necessary and is awarded. The respondent shall pay the medical bills in accordance with the Act, the medical fee schedule or any prior adjustments or negotiated rate. 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.

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

December 17, 2015
Date

DEC 22 2015

FINDINGS OF FACTS: 17IWCC0529

The petitioner, a lessee cab driver, sought medical care for back pain and sweats on February 15, 2015, with Dr. Nigam Patel. He complained of left groin pain and fever for one week. Dr. Patel noted that his physical exam was positive for a non-incarcerated left inguinal hernia and tenderness. He saw Dr. Mohamed Malas at the Advanced Medical Clinic on February 17th for lower back and left groin pain and reported experiencing immediate lower back and left groin pain lifting luggage from the trunk of his cab. It was noted that the petitioner has pus coming out of his left groin. At Advocate Lutheran General Hospital the same day, the petitioner reported back pain for three/four days starting after lifting luggage. He also reported seeing his primary medical doctor, who noted his left inguinal hernia. The diagnosis was acute low back pain and abscess in his left inguinal area. The petitioner saw Dr. Osman for his lumbar pain on February 24th and April 7th, who treated him with medication. The petitioner saw Dr. Shah at Advocate Medical Group the same day and reported feeling severe back pain lifting heavy luggage out of his trunk on February 13th and waking the next day with a swollen and painful left groin. An ultrasound on February 18th revealed a left inguinal hernia.

A lumbar MRI on March 20th revealed disc bulges from L2 through S1 and diffuse spondylosis. An EMG/NCV study on March 17th was compatible with left L4-L5-S1 radiculopathy. Dr. Shah re-evaluated the petitioner on March 24th. A CT scan of his pelvis on March 31st revealed a small left-sided inguinal hernia and spondylolysis at the lumbosacral junction. The petitioner had a left inguinal hernia repair with mesh at Advocate Hospital on April 14th by Dr. Shah. The petitioner followed up with Dr. Shah on April 21st and 30th.

FINDING REGARDING WHETHER THE PETITIONER'S ACCIDENT AROSE OUT OF AND IN THE COURSE OF THE EMPLOYMENT WITH THE RESPONDENT:

Based upon the testimony and the evidence submitted, the petitioner proved that he sustained an accident on February 13, 2014, arising out of and in the course of his employment with the respondent. The medical histories given by the petitioner are consistent with a lifting injury to his lower back and left groin on February 13, 2014.

FINDING REGARDING WHETHER THE MEDICAL SERVICES PROVIDED TO PETITIONER ARE REASONABLE AND NECESSARY:

The medical care rendered the petitioner for his lumbar spine and left inguinal hernia was reasonable and necessary and is awarded.

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 the current condition of ill-being with his lumbar spine and left inguinal hernia is causally related to the work injury. The petitioner's complaints, symptoms and treatment have been continuous and consistent since his injury on February 13, 2014.

FINDING REGARDING THE AMOUNT OF COMPENSATION DUE FOR TEMPORARY TOTAL DISABILITY:

The petitioner was unable to work and did not work from February 15, 2014, through April 29, 2014. The respondent shall pay the petitioner temporary total disability benefits of $319.00/week for 10-4/7 weeks, from February 15, 2014, through April 29, 2014, 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:

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 reasonably inferred from the evidence. Regarding Section 8.1(b)(v), the petitioner complains of some back pain with heavy lifting and on awakening. He has pain and numbness in his abdomen that is increased with movement. The treating medical records do not fully corroborate the testimony.

The respondent shall pay the petitioner the sum of $319.00/week for a further period of 20 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 4% loss of use of the man as a whole for his low back strain and left inguinal hernia.

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIQUE KAY,

Petitioner,

vs. NO: 06 WC 32115

CENTEGRA HEALTH SYSTEM AND
NORTHERN ILLINOIS MEDICAL CENTER,

17IWCC0530

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the May 27, 2016 decision of the circuit court of McHenry County, which affirmed in part and remanded in part the Commission's decision and directed "the Commission to reevaluate the request for penalties, solely, and render a Decision on that issue alone." *Cir. Ct. Dec. at 5.*

This case was consolidated for hearing before the Commission with another case: 05 WC 5517. The circuit court's remand instructions regarding the penalties issue relate solely to that case. We have issued a Decision and Opinion on Remand in the 05 case separately to comply with those instructions. However, from our understanding of the court's order, the 06 case (subject of this decision) has been affirmed and there is nothing further for the Commission to do as it relates to this case.

IT IS THEREFORE ORDERED BY THE COMMISSION that our September 3, 2014 decision stands, based on our understanding that it was affirmed by the circuit court.

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

DATED: AUG 30 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/1/17
49

STATE OF ILLINOIS)
) SS.
COUNTY OF McHENRY)

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

DOMINIQUE KAY,

Petitioner,

vs.

NO: 05 WC 5517

CENTEGRA HEALTH SYSTEM AND
NORTHERN ILLINOIS MEDICAL CENTER,

17IWCC0531

Respondent.

DECISION AND OPINION ON REMAND

This matter comes before the Commission on remand from the May 27, 2016 decision of the circuit court of McHenry County, which affirmed in part and remanded in part the Commission's decision and directed "the Commission to reevaluate the request for penalties, solely, and render a Decision on that issue alone." *Cir. Ct. Dec. at 5.*

This case has a long procedural history, which is not necessary to address here, that culminated in the Commission issuing a decision on September 3, 2014, which modified the permanency award from 60% of a person as a whole under §8(d)2 of the Act down to 50% of a person as a whole. The Arbitrator's decision, dated December 17, 2010, was otherwise affirmed and adopted including the award for medical expenses, temporary total disability periods, and the denial of penalties.

Petitioner filed an appeal to the circuit court on whether the permanency award and the denial of penalties were against the manifest weight of the evidence. The court affirmed the award of 50% of a person as a whole. However, on the issue of penalties, the court found:

> This Court's review of the Decision as contained in the Record has led it to the conclusion that the portion of the Decision addressing penalties is missing. Attempts to obtain the missing page or pages have been unsuccessful.
>
> The section of the Decision addressing penalties ends in midsentence and the following page has not been located despite several months of effort. It is the Court's understanding that the Commission was contacted and denied possession of the subject pages. The absence, or apparent absence, of a portion of the

> document prevents a complete analysis of that Decision. Any attempt to review the underlying Decision regarding penalties would require this Court to speculate as to the basis of the Commission's analysis. Reluctantly, this Court has no alternative but to order the Commission to draft a new Decision on the issue of penalties or locate the missing pages and provide them to this Court.
>
> As a result, this Court is unable to review the Decision regarding penalties with any confidence that it has been fully appraised of the basis of that aspect of the Decision. Accordingly, this Court remands the issue [of] penalties to the Commission with instructions that it review the issue and draft a new decision providing the basis of their conclusion. *Cir. Ct. Dec. at 4-5.*

The Commission acknowledges the error that the Arbitrator's decision, which was attached to ours, ends in midsentence during the discussion of penalties. The Commission has been unable to locate the missing page(s). Although the "Penalties" discussion in the Arbitrator's decision is incomplete and did not clearly state a conclusion, the Order section states that penalties were denied and we affirmed the Arbitrator on that issue. After further review of the decision and the record, we modify that last incomplete sentence, "That respondent was given leave to respond to the penalty petition and has tendered to the arbitrator as Respondent" so that it ends with "Exhibit 26, letters to Petitioner's attorney as well as responses to two penalties petitions."

We also specifically add that Petitioner has failed to prove entitlement to penalties under §19(k) and §19(l), and attorney's fees under §16. We find that Respondent's behavior was not unreasonable nor vexatious and that it had a reasonable basis, at the relevant times, to dispute the requested temporary total disability and medical benefits.

Although the Commission agrees with the Arbitrator and affords greater weight to the opinion of the pain doctor over the opinion of Dr. Vender, Respondent's reliance on Dr. Vender's opinion was not unreasonable. *See Avon Products v. IC*, 82 Ill. 2d 297, 412 N.E.2d 468, 45 Ill. Dec. 117 (1980). Pursuant to the circuit court's order and to avoid any speculation by a reviewing court, we add that the Arbitrator's analysis on the issue of penalties is again affirmed by the Commission with the clarification that our decision is also based on a review of Respondent's Exhibit 26 and the record as a whole.

We hereby reissue and attach our September 3, 2014 decision, along with the Arbitrator's decision, with the additions, modifications, and clarifications noted above.

IT IS THEREFORE ORDERED BY THE COMMISSION that our September 3, 2014 decision is reissued, along with the Arbitrator's decision, with the additions, modifications, and clarifications noted above.

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $512.26 per week for a period of 41-4/7 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 $460.80 per week for a period of 250 weeks, as provided in §8(d)2 of the Act, for the reason that the injuries sustained caused the loss of use of 50% of the person as a whole.

17IWCC0531

IT IS FURTHER ORDERED BY THE COMMISSION that Respondent pay to Petitioner the sum of $21,802.12 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 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 30 2017

Charles J. DeVriendt

Joshua D. Luskin

L. Elizabeth Coppoletti

SE/
O: 8/1/17
49

STATE OF ILLINOIS)
) SS.
COUNTY OF PEORIA)

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

BEFORE THE ILLINOIS WORKERS' COMPENSATION COMMISSION

Michael Wiegers,

Petitioner,

vs. NO: 12WC 40446

State of Illinois/Illinois State Police,

17IWCC0532

Respondent.

DECISION AND OPINION ON REVIEW

Timely Petitions for Review having been filed by both parties and proper notice given, the Commission, after considering the issues of accident, temporary disability, causal connection, permanent disability, medical expenses, motion in limine, 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 27, 2017 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.

17IWCC0532

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

DATED: AUG 30 2017

Stephen J. Mathis

David L. Gore

Deborah L. Simpson

SJM/sj
d-8/3/2017
44

ILLINOIS WORKERS' COMPENSATION COMMISSION
NOTICE OF ARBITRATOR DECISION

WIEGERS, MICHAEL
Employee/Petitioner

Case# **12WC040446**

ST OF IL/ILLINOIS STATE POLICE
Employer/Respondent

17IWCC0532

On 2/27/2017, 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 0.67% 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:

1780 JOHNSON & JOHNSON PC
ANDREWE W JOHNSON
212 E CHESTNUT ST
CANTON, IL 61520

0499 CMS WORKERS' COMP MANAGEMENT
801 S SEVENTH ST 8M
PO BOX 19208
SPRINGFIELD, IL 62794-9208

5300 ASSISTANT ATTORNEY GENERAL
CODY KAY
500 S SECOND ST
SPRINGFIELD, IL 62706

2202 ILLINOIS STATE POLICE
801 S 7TH ST
SPRINGFIELD, IL 62794

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

FEB 27 2017

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

17IWCC0532

STATE OF ILLINOIS)
)SS.
COUNTY OF PEORIA)

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

ILLINOIS WORKERS' COMPENSATION COMMISSION
ARBITRATION DECISION

Michael R. Wiegers
Employee/Petitioner

v.

State of Illinois/Illinois State Police
Employer/Respondent

Case # 12 WC 40446

Consolidated cases: n/a

An *Application for Adjustment of Claim* was filed in this matter, and a *Notice of Hearing* was mailed to each party. The matter was heard by the Honorable William R. Gallagher, Arbitrator of the Commission, in the city of Peoria, on January 19, 2017. 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 1, 2010, Respondent was operating under and subject to the provisions of the Act.

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

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

Timely notice of this accident was given to Respondent.

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

In the year preceding the injury, Petitioner earned $78,825.00; the average weekly wage was $1,505.48.

On the date of accident, Petitioner was 59 years of age, married with 0 dependent child(ren).

Petitioner has received all reasonable and necessary medical services.

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

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

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

ORDER

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

Respondent shall pay Petitioner temporary total disability benefits of $1,003.65 per week for three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014, as provided in Section 8(a) of the Act.

Respondent shall pay Petitioner permanent partial disability benefits of $669.64 per week for 25.625 weeks because the injuries sustained caused the five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) loss of use of the left hand, as provided in Section 8(e) of the Act.

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

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

William R. Gallagher, Arbitrator

February 16, 2017
Date

ICArbDec p. 2

FEB 27 2017

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.

Petitioner initially sought medical treatment on October 1, 2010 (the date of manifestation alleged in the Application) from Dr. Michelle Reeves, his family physician. At that time, Dr. Reeves' findings on examination were consistent with bilateral carpal tunnel syndrome. Dr. Reeves indicated she was going to order EMG/nerve conduction studies. Dr. Reeves stated in her record she considered the condition to be work-related, but did not explain the basis for her opinion (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on October 12, 2010. The studies were consistent with mild bilateral carpal tunnel syndrome as well as chronic moderate cubital tunnel syndrome and bilateral C6-C7 radiculopathy (Petitioner's Exhibit 6).

Petitioner was subsequently seen by Dr. Edwin Card, a general surgeon, on November 8, 2010. Dr. Card examined Petitioner and noted Petitioner had recently undergone nerve conduction studies which were positive for carpal tunnel syndrome. He also indicated Petitioner worked for the State Police, did a significant amount of typing and that Petitioner's complaints were significantly worse when involved in those activities (Petitioner's Exhibit 5).

Petitioner was again seen by Dr. Reeves on May 4 and July 13, 2011, and Petitioner's symptoms had worsened. Dr. Reeves ordered new EMG/nerve conduction studies to be performed (Petitioner's Exhibit 7).

EMG/nerve conduction studies were performed on August 2, 2011. The EMG/nerve conduction studies were positive for moderate chronic bilateral carpal tunnel syndrome as well as suggestive of bilateral C6-C7 radiculopathy (Petitioner's Exhibit 4; Deposition Exhibit B).

At the direction of Respondent, Petitioner was examined by Dr. James Williams, an orthopedic surgeon, on October 3, 2012. In connection with his examination of Petitioner, Dr. Williams reviewed medical records provided to him by Respondent. Dr. Williams agreed Petitioner had bilateral carpal tunnel syndrome; however, he opined that it was not related to Petitioner's work activities of typing. Dr. Williams referenced literature in *The Journal of Hand Surgery* which stated there was no relationship between typing and the development of carpal tunnel syndrome. He also noted Petitioner had hypertension, but opined it was more likely the carpal tunnel syndrome was of idiopathic origin (Respondent's Exhibit 4; Deposition Exhibit 2).

Dr. Reeves continued to treat Petitioner primarily for his neck condition, which was not alleged to be work-related, for several months. When Dr. Reeves saw Petitioner on December 5, 2012, she referred him to Dr. Christopher Wottowa, an orthopedic surgeon, for the bilateral carpal tunnel syndrome (Petitioner's Exhibit 7).

In regard to the bilateral carpal tunnel syndrome condition, Petitioner was initially evaluated by Dr. Wottowa on February 18, 2013. Dr. Wottowa had previously treated Petitioner in 2006 and 2007 for bilateral cubital tunnel syndrome and performed ulnar transposition surgeries. Dr. Wottowa released Petitioner from treatment and authorized him to return to work in March, 2007, following those surgeries (Petitioner's Exhibit 4; Deposition Exhibit B).

When Dr. Wottowa saw Petitioner on February 18, 2013, Petitioner advised he had numbness/tingling in both hands which he associated with typing at work. Dr. Wottowa reviewed the prior EMG/nerve conduction studies and opined Petitioner had bilateral carpal tunnel syndrome. Prior to making a decision about whether to proceed with carpal tunnel release surgeries, Dr. Wottowa ordered further EMG/nerve conduction studies. Petitioner had EMG/nerve conduction studies performed on June 13, 2013, which were positive for bilateral carpal tunnel syndrome (Petitioner's Exhibit 4; Deposition Exhibit B).

Dr. Wottowa subsequently performed carpal tunnel release surgeries on Petitioner's left and right hands on December 10, 2013, and December 16, 2014, respectively (Petitioner's Exhibit 4; Deposition Exhibit B). Following both surgeries, Petitioner was able to return to work to his regular job without restrictions.

Dr. Williams was deposed on March 10, 2016, and his deposition testimony was received into evidence at trial. On direct examination, Dr. Williams testified Petitioner had bilateral carpal tunnel syndrome, but that the duties of typing did not cause or aggravate the condition. He based this opinion on an article contained in *The Journal of Hand Surgery* that he referenced in his report and stated the condition was likely idiopathic. Dr. Williams testified Petitioner did not have any other risk factors including increased body mass, hypertension, diabetes or thyroid dysfunction (Respondent's Exhibit 3; pp 8-11). The Arbitrator notes that in Dr. Williams report he described Petitioner as having hypertension; however, when deposed he testified that this was not a risk factor.

When cross-examined, Dr. Williams agreed he did not have knowledge of the ergonomics of Petitioner's workstation and had never seen any photographs of it. He also agreed he previously opined in another case that typing for four hours could cause carpal tunnel syndrome, but that he changed his opinion about typing as being the cause of that condition (Respondent's Exhibit 3; pp 31-38).

When cross-examined, Dr. Williams was asked what percentage of his practice consisted of performing Section 12 examinations, and he testified it was less than five percent (5%). In regard to the percentage of Section 12 examinations Dr. Williams performed for Respondent, he testified it was 30% and denied that it was over 50% in prior years. Petitioner's counsel then referenced a Decision of the Commission wherein he (Dr. Williams) performed approximately one half of his IMEs for Respondent and was asked whether this was accurate. Dr. Williams responded that it was not accurate (Respondent's Exhibit 3; pp 14-20). The preceding was the primary basis of Petitioner's counsel's Motion in Limine to exclude Dr. Williams' testimony which, as previously noted herein, was denied by the Arbitrator.

Dr. Wottowa was deposed on April 25, 2016, and his deposition testimony was received into evidence at trial. In regard to his treatment of Petitioner, Dr. Wottowa's records were tendered as an evidentiary exhibit when he was deposed. In regard to the etiology of Petitioner's bilateral carpal tunnel syndrome, Dr. Wottowa testified that Petitioner's typing would not cause the carpal tunnel syndrome condition; however, he stated Petitioner's typing activities would be an "aggravating factor" of the condition (Petitioner's Exhibit 4; pp 26-28).

On cross-examination, Dr. Wottowa was questioned about other risk factors for the development of carpal tunnel syndrome. Dr. Wottowa declined to categorize the development of carpal tunnel syndrome as being "idiopathic" but described it was "multi-factorial," and that it was possible Petitioner would have developed carpal tunnel syndrome even without his job. However, Dr. Wottowa also stated Petitioner did not have any comorbidities for development of carpal tunnel syndrome, specifically, diabetes, obesity, cigarette smoking and uncontrolled hypertension. While he noted Petitioner had hypertension, he also noted it was controlled and not a risk factor (Petitioner's Exhibit 4; pp 33-35).

In regard to the postsurgical condition of Petitioner's hands, Dr. Wottowa testified Petitioner had no work restrictions, had no condition of ill-being in regard to his carpal tunnel syndrome, normal function and an excellent prognosis. When cross-examined, Dr. Wottowa agreed Petitioner had no disability as a result of the carpal tunnel syndrome (Petitioner's Exhibit 4; pp 30, 39).

When the case was tried, Petitioner's right lower arm/hand was in a cast. Petitioner testified he recently had surgery performed on his right thumb, but it was not for a work-related condition. In regard to his right wrist/hand, Petitioner stated he had virtually no symptoms at all. In regard to his left wrist/hand, Petitioner stated he still had some pain in his left wrist, but it was very infrequent.

Conclusions of Law

In regard to disputed issues (C) and (F) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner sustained a repetitive trauma injury to his right and left hands that manifested itself on October 1, 2010, and that his current condition of ill-being is causally related to same.

In support of this conclusion the Arbitrator notes the following:

The date of manifestation, October 1, 2010, was when Petitioner was examined by Dr. Reeves and the findings on examination were consistent with carpal tunnel syndrome.

There was no dispute that Petitioner had bilateral carpal tunnel syndrome.

Petitioner's testimony regarding his work activities which required the daily repetitive use of both of his hands while at work was unrebutted.

Petitioner's treating physician, Dr. Wottowa, opined that while Petitioner's work activities did not cause Petitioner's bilateral carpal tunnel syndrome, the work activities were an aggravating factor.

Petitioner did not have any of the comorbidities that contribute to the development of carpal tunnel syndrome, specifically, diabetes, obesity and cigarette smoking. Petitioner did have

hypertension; however, this was controlled with medication and thereby not considered to be a risk factor.

Respondent's Section 12 examiner, Dr. Williams, opined Petitioner's bilateral carpal tunnel syndrome condition was not work-related; however, this opinion was based largely on an article he referenced contained in *The Journal of Hand Surgery*. Dr. Williams agreed he had previously opined that typing for four hours could cause carpal tunnel syndrome. Further, Dr. Williams conceded Petitioner did not have any of the other risk factors for the development of carpal tunnel syndrome including increased body mass, hypertension, diabetes or thyroid dysfunction.

Based upon the preceding, the Arbitrator finds the opinion regarding causality of Dr. Wottowa to be more persuasive than that of Dr. Williams.

In regard to Dr. Williams' alleged "perjury" about percentage of examinations he had performed at the request of Respondent, the Arbitrator is not persuaded by this. The Arbitrator notes that Section 12 examinations amount to less than five percent (5%) of Dr. Williams' overall medical practice. While Dr. Williams may have been in error regarding the percentage of Section 12 examinations he performed for Respondent, it is insignificant if was 30% or 50% of the five percent (5%) of his overall practice. In this regard, Dr. Williams' testimony regarding same should be evaluated in the context that such examinations constitute a very small percentage of his total medical practice. Accordingly, this was not a factor in the Arbitrator's finding as to which physician was a more persuasive.

In regard to disputed issue (J) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes that all of the medical treatment provided to Petitioner in regard to his bilateral carpal tunnel syndrome condition was reasonable and necessary and Respondent is liable for payment of the medical bills incurred therewith.

Respondent shall pay reasonable and necessary medical services as related to Petitioner's bilateral carpal tunnel syndrome condition, as identified in Petitioner's Exhibit 9, as provided in Sections 8(a) and 8.2 of the Act, subject to the fee schedule. Respondent shall be given a credit of amounts paid for medical benefits that have been paid, and Respondent shall hold Petitioner harmless from any claims by any providers of the services for which Respondent is receiving this credit, as provided in Section 8(j) of the Act.

In regard to disputed issue (K) the Arbitrator makes the following conclusions of law:

The Arbitrator concludes Petitioner is entitled to temporary total disability benefits of three and three-sevenths (3 3/7) weeks commencing December 10, 2013, through December 18, 2013, and December 16, 2014, through December 30, 2014.

In support of this conclusion the Arbitrator notes the following:

There was no dispute Petitioner was temporarily totally disabled during the aforestated periods of time.

In regard to disputed issue (L) the Arbitrator makes the following conclusion of law:

The Arbitrator concludes Petitioner has sustained permanent partial disability to the extent of five percent (5%) loss of use of the right hand and seven and one-half percent (7 1/2%) loss of use of the left hand.

In support of this conclusion the Arbitrator notes the following:

In regard to both hands, Dr. Wottowa opined Petitioner had no condition of ill-being, normal function, an excellent result and no disability.

In regard to the right hand, Petitioner had virtually no symptoms at all in regard to same.

In regard to the left hand, Petitioner had complaints of pain in the left wrist, but it was very infrequent.

Based upon the preceding, the Arbitrator finds Petitioner had an excellent surgical result and has minimal functional loss of use of both hands.

William R. Gallagher, Arbitrator

Preliminary Ruling

This case was tried in Peoria on January 19, 2017. Petitioner's counsel previously filed a Motion in Limine wherein he moved the Arbitrator exclude the deposition testimony of Respondent's Section 12 examining physician, Dr. James Williams. In that motion, Petitioner's counsel argued the Dr. Williams committed perjury when he was deposed in regard to the percentage of examinations he performed at the request of Respondent. Further, Petitioner's counsel represented that Dr. Williams had a financial bias based upon the income he derived from performing examinations at the request of Respondent. Because of the preceding, Petitioner's counsel argued that Dr. Williams' testimony be excluded, in its entirety, because it was unreliable and prejudicial to be admitted into evidence (Petitioner's Exhibit 3).

Respondent's counsel filed a Response to Petitioner's Motion in Limine wherein he stated that Dr. Williams did not perjure himself when he was deposed. Further, Respondent's counsel stated that excluding Dr. Williams' testimony would violate Respondent's rights of due process (Respondent's Exhibit 4).

Petitioner's Motion in Limine was previously argued before the Arbitrator in October, 2016. At that time, the Arbitrator denied the motion because the issues raised by Petitioner's counsel related to the credibility of the witness and what probative value should be given to his testimony. The Arbitrator found this was not a basis to exclude, in its entirety, Dr. Williams' testimony. When this case was tried on January 19, 2017, the Arbitrator reaffirmed this ruling on the record.

Findings of Fact

Petitioner filed an Application for Adjustment of Claim which alleged he sustained a repetitive trauma injury arising out of and in the course of his employment for Respondent. The Application alleged a date of accident (manifestation) of October 1, 2010, and that Petitioner sustained repetitive trauma to bilateral hands and arms (Petitioner's Exhibit 1). Respondent disputed liability on the basis of accident and causal relationship (Arbitrator's Exhibit 1).

Petitioner began working for Respondent in October, 1986, and worked up until he retired on December 31, 2016. For approximately 25 years, Petitioner was an Intelligence Analyst. Petitioner claimed he sustained bilateral carpal tunnel syndrome as a result of typing/keyboarding. Petitioner testified he was right hand dominant and used both of his hands for typing for virtually 95% of every workday.

At trial, Petitioner's counsel tendered into evidence eight photographs of Petitioner's workstation which included two separate keyboards and pads Petitioner rested his hands on when he was typing (Petitioner's Exhibit 10). Petitioner testified he would generally hold his hands at about a 45° angle when he was typing. Petitioner would hold his hands at the same angle on both keyboards. Petitioner's other duties at work included answering the telephone, handwriting and filing.